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Trends in London's NHS Workforce

An updated analysis of key data

Ruth Hutt

James Buchan

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AN UPDATED ANALYSIS OF KEY DATA

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This working paper examines how London's health care labour market is developing in the context of London-specific factors that affect recruitment and retention of NHS staff. It updates previous work undertaken by the King's Fund for *In Capital Health?* through the analysis of more recent data, and looks at some of the challenges lying ahead as changes in medical staff contracts take effect and Agenda for Change is implemented.

About the authors

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Introduction

The NHS is one of London's largest employers, directly employing nearly 200,000 staff (excluding workers in contracted-out services). This represents 15–20 per cent of England's total NHS workforce. However, there are a number of factors specific to London that present the NHS in London with unique problems in recruiting and retaining its workforce.

The specific dynamics of the London health care labour market, and the challenges these create for recruitment and retention, were highlighted in the 2003 King's Fund report: *In Capital Health? Creative solutions to London's NHS workforce challenges* (Buchan *et al* 2003). In the 18 months since, a number of important and far-reaching changes have been initiated across the NHS.

This working paper aims to outline the evolving picture of how London's health care labour market is performing within the context of these changes by comparing the findings of *In Capital Health?* with more recent data. It also looks at the challenges lying ahead and some possible ways forward.

The findings of *In Capital Health?*

In Capital Health? identified a number of factors that make London a unique and complex health care labour market in which to operate. High entry costs owing to the price of accommodation, as well as transport and infrastructure issues, can deter NHS staff from working in the capital, and the high proportion of young, mobile (and sometimes internationally transient) health workers in London can create difficulties with staff retention. At the same time, the NHS in London serves an ethnically diverse population with relatively large numbers of refugees, who could provide a potential source of health workers.

Taking account of these features, *In Capital Health?* identified ten key challenges for the policy-makers and human resources managers who are responsible for planning and managing London's NHS workforce. These were:

- managing staff turnover
- managing vacancies
- recruiting new staff
- recruiting experienced staff from elsewhere in the United Kingdom
- recruiting staff from abroad
- retaining staff
- attracting staff back
- improving the use of temporary staff
- planning for an older workforce
- ensuring equal opportunities and widening entry routes.

The wider context of change

The NHS Plan (Department of Health 2000) pledged to increase the number of staff across the NHS, particularly the numbers of doctors and nurses. While this planned growth continues to provide a backdrop to NHS workforce dynamics in London, the following issues have also become more prominent during the past year.

For doctors, it has been a time of great change. Under the terms of the new consultant contract, consultants agree with their clinical manager a working week divided into 'programmed activities', including any predictable on-call commitments. These activities are divided into: direct clinical care; supporting professional activities (such as audit, research, appraisal); additional NHS responsibilities (such as being a medical director); and external duties (such as work for a union or other professional organisation). The new General Medical Service (GMS) contract has provided greater flexibility for general practitioners (GPs), giving them some choice over the services that they provide as well as the option to opt out of providing out-of-hours cover. Before these contracts were implemented, considerable planning was required to ensure that adequate cover remained available for out-of-hours services. Junior doctors and other NHS staff have also been affected by the European Working Time Directive (EWTD), which limits the number of hours they can work each week.

All other NHS staff will be starting to experience a fundamental and wide-reaching change as the Agenda for Change (AfC) is implemented. AfC is a new pay system that is underpinned by a single job evaluation scheme, and linked to a career structure based on the Knowledge and Skills Framework (Department of Health 2004a). This approach should facilitate the development of new roles for NHS staff. Health care professionals will no longer be constrained by their own professional pay scales; instead they will be able to develop their roles based on competence and the jobs they are actually doing, encouraging new career routes and individual career development.

In London, as in the rest of the NHS, these changes have added to the existing challenges of staff recruitment, motivation and performance. This expanded and challenging agenda is a critical component of the 'modernised' NHS. Its success will depend on the availability of sufficient management capacity within NHS human resources, with the NHS Confederation taking on a new role as the lead organisation for NHS employers.

What this study found

Since the publication of *In Capital Health?* in 2003, staffing growth has continued in the London NHS workforce, with an increase in the numbers of doctors, nurses and allied health professionals (AHPs). However, at the time of writing the data suggests that growth has varied across different occupations and parts of the capital. The 2004 workforce census data (*see* Methodology, p 3) is not yet available, so it is impossible to say whether this trend is continuing.

WHOLE-TIME EQUIVALENT (WTE) INCREASE IN THE LONDON NHS WORKFORCE, APRIL–SEPTEMBER 2003

Professional group	WTE increase
Nurses, midwives and health visitors	6,553
General practitioners*	637
Allied health professionals	399
Consultants	278

*GP data is based on headcount

Meanwhile, the factors that make London a unique and complex health care labour market in which to operate remain largely unchanged. As a result, none of the challenges of recruitment and retention highlighted in *In Capital Health?* have disappeared, although some of these challenges are now being addressed more effectively. This is reflected in the following indicators:

- a reported reduction in spending on agency nursing staff
- increases in the numbers of mature students entering training
- an increase in the proportion of applicants for nurse training already resident in London
- reported improvements in child care provision
- the widening of access routes into health care professions.

However, certain issues are continuing to cause real problems:

- staff turnover remains high, with London accounting for around one-third of all NHS vacancies across England
- recruitment to the allied health professions in the capital continues to be difficult
- GP vacancies remain high, with shortages likely to increase in the future.

New challenges, which are also the focus of King's Fund work, include:

- some of London's mental health trusts are having particular problems recruiting doctors and nurses
- the imminent implementation of chronic disease management initiatives will put additional pressure on primary care and community nursing services.

Methodology

The Department of Health conducts an annual workforce census of all NHS staff in September each year, and a vacancy survey in March each year. The most recent vacancy data available for London is from March 2004, and the workforce census data is from September 2003 (data from the 2004 census was unavailable at the time of writing). A summary of this workforce census data is shown in Table 1 (*see* p 5). We have undertaken this analysis of the London workforce using the dataset supplied by the Department of Health. Additional data has been provided from other sources including the Nursing and Midwifery Admissions Service (NMAS), the British Medical Association (BMA), NHS Professionals, Office for Manpower Economics (OME) as well as other published sources, and is referenced where presented.

The structure of this paper

This working paper has two main parts. The first part is divided into ten sections – each addressing one of the ten challenges identified in *In Capital Health?*. For each challenge, the original findings are compared with more recent data from various sources to establish where progress has been made and what challenges remain. Each section begins with a brief summary of the main findings relating to the challenge in question.

The second part looks toward the future, examining the current state of the London NHS workforce, the challenges that are emerging at both local and national levels, and some of the steps that can be taken to address these challenges.

Who is this paper for?

This analysis of the current state of the London NHS workforce is aimed at stakeholders within NHS human resources and workforce planning communities who may find the information helpful in planning for the challenges that lie ahead.

The paper focuses specifically on London, which tends to face slightly different and more severe challenges than other parts of the United Kingdom in the recruitment and retention of certain staff groups. However, to an extent, many of the issues discussed are relevant to the whole of the NHS and therefore will also be of interest to those in the wider NHS community.

The King's Fund workforce programme

This working paper forms part of a wider King's Fund programme of research and development activities focused on London's NHS workforce, launched in 2002, that aims to address the problems of recruitment and retention that present major challenges to the health service – particularly in inner cities.

Papers to be published later in 2005 will explore some of the issues raised in this paper in more detail. One will look at how policy is delivered within the primary and community-care NHS workforces, focusing on the challenges created by policies such as chronic disease management, the provision of enhanced services and the new GMS contract. Another is a report from our ongoing work on internationally recruited nurses exploring the experiences of nurses who have trained overseas but are currently working in the NHS.

TABLE 1: CURRENT NHS WORKFORCE AS OF SEPTEMBER 2003

	North West London SHA		North East London SHA		North Central London SHA		South East London SHA		South West London SHA		London	
Staff group	WTE	headcount	WTE	headcount	WTE	headcount	WTE	headcount	WTE	headcount	WTE	headcount
Professionally qualified clinical staff (non-medical)	**16,753.1**	**20,198**	**12,387.8**	**14,944**	**14,680.4**	**17,314**	**14,920.0**	**18,332**	**10,496.2**	**13,212**	**71,393.9**	**86,193**
Qualified nursing, midwifery and health visiting staff	12,626.8	15,556	9,416.0	11,646	10,501.1	12,553	11,024.1	13,930	7,503.3	9,679	51,071.3	63,364
All qualified scientific, therapeutic and technical staff*	4,122.3	4,638	2,971.8	3,298	4,179.3	4,761	3,878.9	4,385	2,993.0	3,533	18,145.2	20,615
of which:												
qualified allied health professionals	1,626.7	1,852	1,250.1	1,369	1,539.9	1,768	1,432.2	1,651	1,150.5	1,412	6,999.5	8,052
Support to clinical staff	**8,708.6**	**11,033**	**7,724.3**	**9,903**	**6,970.3**	**8,443**	**7,947.0**	**9,800**	**5,781.2**	**7,558**	**38,123.1**	**47,766**
NHS infrastructure support	**5,827.5**	**6,273**	**5,137.2**	**5,650**	**4,982.6**	**5,417**	**4,968.9**	**5,432**	**3,714.4**	**4,187**	**25,205.2**	**27,549**
Practice nurses (employed by GP practices)	**492.8**	**761**	**324.3**	**549**	**295.2**	**445**	**312.3**	**510**	**329.5**	**556**	**1,754.1**	**2,821**
Practice staff (employed by GP practices)	**2,040.2**	**3,232**	**1,723.2**	**2,654**	**1,313.7**	**1,993**	**1,492.4**	**2,420**	**1,300.9**	**2,106**	**7,870.3**	**12,405**
Medical and dental staff (including GPs)	**4,629.4**	**5,186**	**3,226.3**	**3,425**	**4,063.3**	**4,531**	**4,048.9**	**4,489**	**2,912.0**	**3,188**	**18,880.0**	**20,819**
General practitioners	943.5	1,001	751.2	796	666.4	705	811.7	880	688.2	752	3,860.9	4,134
Hospital, public health medicine and community health service (HCHS) medical and dental staff	3,685.9	4,185	2,475.2	2,629	3,396.9	3,826	3,237.2	3,609	2,223.8	2,436	15,019.1	16,685
of which:												
consultants	1,206.7	1,415	824.0	904	1,207.0	1,416	1,174.6	1,361	759.1	845	5,171.4	5,941
community dental staff	35.6	53	33.2	41	34.8	41	34.2	43	20.7	30	158.5	208
Total	**38,451.6**	**46,683**	**30,523.1**	**37,125**	**32,305.4**	**38,143**	**33,689.4**	**40,983**	**24,534.2**	**30,807**	**163,226.5**	**197,553**

Table notes
Data supplied by Department of Health based on September 2003 census.
GP data covers all Unrestricted Principal Equivalents (UPEs) but excludes GP registrars and retainers.
Numbers throughout have been rounded to nearest decimal point.
*Excludes 21 qualified ambulance staff included in professionally qualified clinical staff.

Definitions:
WTE: whole-time equivalent.
UPE: a medical practitioner contracted by the primary care trust or health authority to provide the full range of general medical services.
GP registrar: a registered medical practitioner on a GP training scheme.
Retainer: a registered medical practitioner employed as an assistant by a general practice to provide service sessions.

Ten key challenges

Challenge 1: Managing staff turnover

Turnover in all NHS staff groups is consistently higher in London than in England as a whole. However, in London the turnover of registered nurses fell between 2000 and 2003, whereas across the country this has remained steady. In the future, it is likely that London will continue to have a high turnover of NHS staff, creating an ongoing challenge for NHS employers in the capital.

Turnover is measured as the number of employees who have left a post, changed organisation or left the NHS altogether. High turnover rates can act as a significant drain on resources and may indicate difficulties with recruitment and retention. However, some turnover is desirable to allow for career progression and the entry of new staff into the service.

The Office for Manpower Economics (OME) conducts an annual survey of the turnover of employee groups within the NHS on behalf of the Nursing and Other Health Professionals Review Body (the most recent survey data available is for 2003). Staff turnover in the London NHS tends to be higher than in the rest of England (*see* Figures 1 and 2, opposite). Between 2000 and 2003, the trend in the turnover of registered nurses in England remained fairly stable at around 13–14 per cent (Office for Manpower Economics 2003a). Meanwhile, in inner London, the trend in turnover dropped in 2001 and 2002, before increasing slightly in 2003 (Office for Manpower Economics 2003b).

In London, turnover among the allied health professions (which includes therapists, dieticians, radiographers, orthoptists, paramedics and prosthetists) has fluctuated between 2000 and 2003 (Office for Manpower Economics 2003c), but has remained consistently higher than across England as a whole, with an apparent upward shift in 2003.

In the future, London will continue to have high staff turnover relative to the rest of the NHS. The factors that attract people to work in the London NHS, such as training opportunities for more junior staff and opportunities to specialise and get rapid promotion for more senior staff, are likely to remain in place. At the same time, heavy workloads and a lack of affordable child care, high-quality schools and affordable housing will continue to push staff out of London as their careers progress. As a result of these factors, the need to manage the 'churn' created by significant turnover of staff and the relatively high use of temporary staff (*see* pp 16–17 for further discussion) will continue to provide a major challenge for employers in the capital.

1 **TURNOVER IN REGISTERED NURSES 2000 TO 2003 AS A PERCENTAGE OF STAFF IN POST**

Source: OME 2003
Note: Response rates vary by region and by year, so year to year turnover comparison should be interpreted with caution

2 **TURNOVER IN ALLIED HEALTH PROFESSIONALS 2000 TO 2003 AS A PERCENTAGE OF STAFF IN POST**

Source: OME 2003
Note: Data matched for years 2000/2001 and 2002/2003 for those trusts responding to both years' surveys

Challenge 2: Managing vacancies

Recent data suggests that vacancy rates for all NHS posts other than doctors remain higher in London than for all of England and are often twice as high. General practitioner (GP) vacancies in London have steadily increased. The Department of Health is working to remedy this situation by offering incentives to doctors returning to general practice. By contrast, vacancy rates for consultant posts are lower in London than across the country. This may be due to the number and range of specialties and teaching hospitals in the capital.

Vacant posts in the NHS can indicate staff shortages. Where this is the case, vacancies create a heavier workload for remaining staff, who have to cover for the empty posts. This in turn can impede efforts to retain staff, creating further vacancies. The result is a vicious circle of high staff turnover, with a heavy reliance on using agency staff.

The NHS Staff Vacancies Survey is conducted annually (most recently in March 2004) and covers all NHS trusts in England. It requests details of posts that trusts have been actively trying to fill but which have remained empty for three months or more. These longer-term vacancies can indicate recruitment difficulties.

Figure 3 below shows the three-month vacancy rates for some of the main staff groups in the NHS at 31 March 2004. Staff vacancy rates in London generally remain higher than in the rest of England, with the exception of consultant posts. The numbers of vacancies for qualified nurses,

3 **POSTS VACANT FOR THREE MONTHS OR LONGER AS A PROPORTION OF ALL POSTS IN LONDON AND ENGLAND AS OF MARCH 2004**

Source: Department of Health vacancy survey 2004

midwives, unqualified nursing staff and allied health professionals (AHPs) in London are all about twice the national average or more. In March 2004, 2,719 registered nurse vacancies of three months or more were reported in London. This is a slight increase in vacancies after a downward trend that ended with a four-year low of 2,611 in 2003. As yet, it is too early to say whether the increase seen in 2004 reflects a change in the trend.

While the Department of Health's annual survey does not report vacancies by grade, the annual OME workforce survey asks NHS trusts whether they experience problems recruiting and retaining nurses and AHPs by grade. The survey is national and was last reported for 2003. At that time, trusts most frequently reported problems recruiting for the following nursing posts: grade E (staff nurse) posts with 70 per cent of trusts reporting problems; the more junior grade D (staff nurse) posts with 56 per cent of trusts reporting problems; and the more senior grade G (ward manager/specialist nurse) posts with 51 per cent of trusts reporting problems. Within allied health professions, recruitment problems were more likely for the middle grades of senior II or senior I.

More recent informal feedback from NHS employers in London suggests that the situation has been changing in the capital, with the most pronounced problems in nursing being reported in the recruitment of experienced nurses at grades E, F or above. International recruitment and other initiatives (such as return-to-practice courses and supervised-practice placements for overseas nurses already living in London) appear to have had a positive impact on filling the more junior grade D nursing posts.

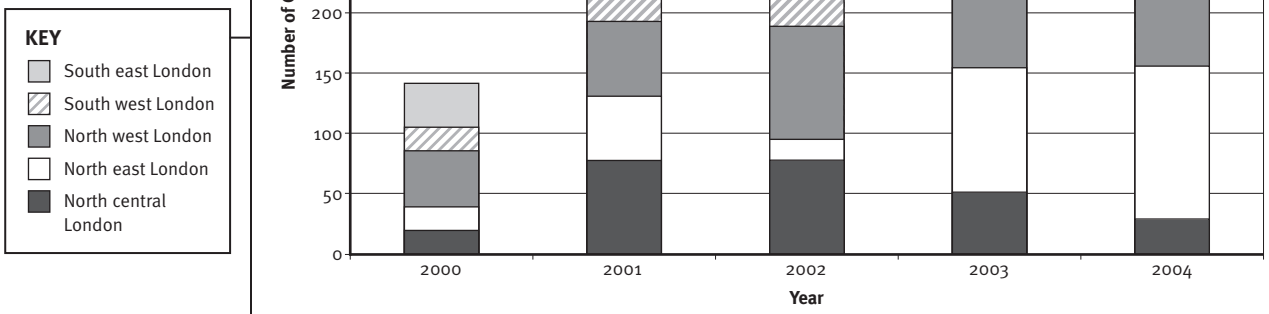
The vacancy rate for medical consultant posts suggest that the NHS in London appears to experience fewer problems filling these posts than other parts of England. This may be due to the number and range of specialties and teaching hospitals in the capital.

General practitioner vacancies

In general, there is a rising trend in the number of GP vacancies in London. However, the extent of the problem varies across the five strategic health authorities. Information supplied by the London Workforce Development Confederations in April 2003 presented a snapshot of all GP vacancies in London. The data showed a vacancy rate of 7 per cent across London, which was more than twice the rate reported for England as a whole (London Assembly Health Committee 2003).

There is a rising trend in the number of GP vacancies over time (*see* Figure 4, overleaf). From April 2003 to March 2004, 424 vacancies were reported across London. Some parts of the capital, such as south east London and north east London, appear to be experiencing higher numbers of vacancies than others. The findings of the London Assembly Health Committee estimate that an increase in GP numbers of 30 per cent is needed in London in order to fill current vacancies, meet the requirements of the *NHS Plan* and provide a high-quality primary care service. In order to attract doctors into general practice the Department of Health has set up incentives such as the 'golden hello' scheme, which comprises a payment of £12,000 to doctors returning to take up posts in general practice. From April 2005, these schemes will be targeted at deprived and 'under doctored' areas rather than applied universally (Department of Health 2004b). This may enable London to compete more effectively for GPs against surrounding areas, which are less likely to be eligible for such schemes.

4 **TOTAL NUMBER OF GP VACANCIES PER YEAR IN LONDON 2000 TO 2004**



Source: Department of Health 2004
Note:
In 2003, one primary care trust in south west London did not respond.
In 2002 and 2001, one health authority, which made up part of south west London, did not respond to the survey.

Challenge 3: Recruiting new staff

Efforts to widen access routes have helped to increase the proportion of mature students entering professional training for medicine and nursing, and the proportion of student nurse applicants already resident in London at the time of application has also increased. These trends may help to reduce the flow of staff out of the capital after training.

Traditionally, London has 'imported' health professionals for the purposes of training, but has then 'exported' many of these London-trained staff to the rest of the NHS. This pattern can be explained by the number of specialist teaching hospitals in London, which make the city an attractive training location in which to gain professional experience.

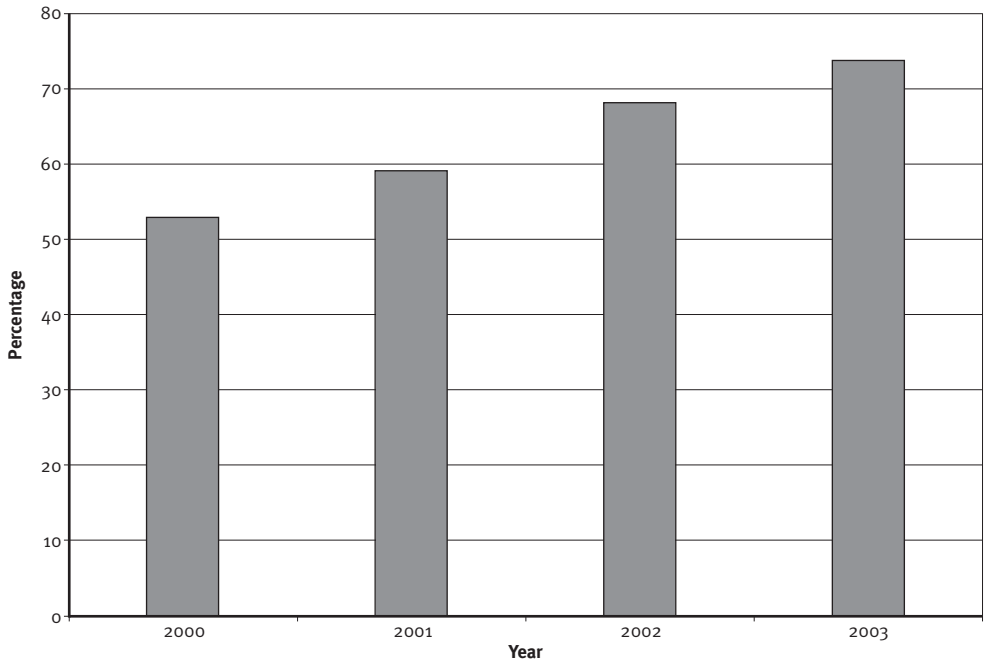
In the past, people have tended to make the decision to enter a health care profession when leaving school at 17 or 18 years of age. This trend is changing as many more 'late' entrants undertake training after a change of career or simply at a later stage in life. In nursing, for example, there has been a rising trend in the proportion of mature students entering training (NMAS 2004). Figures from 2003 show that London has the highest proportion of student nurse entrants over 26 years old at 57 per cent, compared with an average of 46 per cent across England as a whole (University Central Admissions Service, personal communication 2004). The advantages of this for the NHS in London are twofold: first, mature students are likely to

come from a diverse range of backgrounds and experiences and thus better reflect the patient population; and second, they are more likely to have put down roots locally – increasing the likelihood that they will choose to work in London after graduating.

During the last four years, there has been a steady rise in the proportion of applicants for nursing diploma courses in London who are already resident in the capital (*see* Figure 5, below), and it is probable that a significant proportion of these are mature students. 'Secondment programmes', in which health care assistants receive a salary rather than a bursary to begin training as a nurse, may have contributed to this trend. An evaluation of such a scheme in London found that none of the participants would have contemplated training as a nurse without this opportunity (Gould *et al* 2004). In the long term, such schemes may help to reduce the flow of trained staff out of the capital after training.

In contrast with nursing, only a small proportion of entrants to medical school are over 25 years (9 per cent in 2003), although this still represents a threefold increase since 1997. The new medical schools established since 2000 have attracted a higher proportion of mature students, and increasing numbers of medical schools are running entry programmes to medicine for those already holding a degree. This is likely to make an important contribution to increasing the proportion of mature students and meeting the required increase in medical students, given a background drop in applicants to medical schools nationally (British Medical Association 2004a).

5 **PERCENTAGE OF NURSING DIPLOMA APPLICANTS TO LONDON INSTITUTIONS THAT LIVE IN LONDON**



Source: NMAS 2004

Challenge 4: Recruiting experienced staff from elsewhere in the United Kingdom

Attracting staff to London from elsewhere in the United Kingdom remains a challenge owing to high living costs. Following the implementation of the Agenda for Change (AfC), increases to the London 'weighting' allowance based on a percentage of basic pay will increase the salaries of most NHS staff working in London and may help to make the capital a more appealing place to work.

Recruiting experienced staff from outside of London is vital in order to fill vacancies and bring experienced staff into the capital. While London has a lot to offer with regard to training and specialised services that provide unique experience and opportunities, the high cost of living and working in London is a potential barrier to attracting staff from outside the capital.

While this problem was once unique to London, the entire south east of England now has higher house prices compared with the rest of the United Kingdom. However, at the bottom end of the market, London prices are still nearly twice that of the south east. This makes it virtually impossible for staff on even relatively senior grades to enter the housing market without additional financial support.

Agenda for Change includes changes to the London allowances that are currently provided under the Whitley system, a pay-scheme that has been in place since the inception of the NHS. Instead of being fixed sums, London allowances for NHS staff will become a percentage of basic pay: 15 per cent for outer London and 20 per cent for inner London. This represents a salary increase for most staff. The new London allowances will also be pensionable, unlike the current London weighting allowance.

TABLE 2: CURRENT AND PROPOSED LONDON ALLOWANCES

	Whitley	Agenda for Change	
Area	**Current allowances**	**Minimum**	**Maximum**
Inner London	£3,441	£3,197	£5,328
Outer London	£2,688	£2,664	£3,729
Fringe	£753	£799	£1,385

Source: www.dh.gov.uk 2004

If areas outside of London experience difficulties in recruiting and retaining an NHS workforce, they will be able to use 'recruitment and retention premia' when AfC has been fully implemented – extra payments they can award to increase salaries – in order to attract staff. The maximum value of these will be 30 per cent of salary.

The new allowances will require close monitoring to see what impact they have on recruitment and retention problems in London relative to the rest of the country. Measuring impact will be particularly important in areas linked to London by direct transport routes that lie just outside the area eligible for London allowances. While the allowance may benefit London NHS trusts by enabling them to attract staff who live in these areas, it may have a detrimental effect on NHS trusts located just outside the London boundaries.

Challenge 5: Recruiting staff from abroad

London continues to have a higher proportion of staff recruited from overseas than elsewhere in the United Kingdom, and remains vulnerable to losing them to other health economies, such as the United States and Canada. Schemes to integrate medically trained refugees into the NHS workforce could help to alleviate staff shortages.

The NHS relies heavily on professional staff recruited from overseas. It is unlikely that the targets set in the *NHS Plan* for the expansion of the NHS workforce could have been achieved without overseas recruitment. This is particularly the case in London, which attracts overseas staff both on its own merit and because London-based employers have actively recruited health care professionals from other countries inside and outside the European Union (EU).

A survey of members of the Royal College of Nursing found that 3 per cent of UK nurses are trained overseas compared to 13 per cent in London (Ball and Pike 2004). The King's Fund has an ongoing research programme examining international recruitment and the experiences of health care workers coming to the United Kingdom. The initial findings reported in *London Calling* demonstrated the heavy reliance of London trusts on internationally recruited nurses, with the three trusts surveyed reporting that overseas trained nurses constituted between 12 and 25 per cent of their qualified nursing workforce (Buchan *et al* 2004). The majority of these overseas trained nurses came from the Philippines, Australasia, India, Ghana and Nigeria. The findings of the research also suggested that the overseas recruitment initiatives have been successful in filling basic-level (grades D and E) qualified nursing posts, which were previously hard to fill. A more detailed report of the experiences of overseas trained nurses will be available later in 2005.

A reliance on overseas staff is also apparent in medicine. Table 3 below shows the percentage of all doctors and consultant grade doctors in the NHS by the country of their undergraduate medical degree.

TABLE 3: PERCENTAGE OF ALL UK DOCTORS AND CONSULTANTS BY LOCATION OF UNDERGRADUATE MEDICAL TRAINING

	UK	EU	Elsewhere
Consultants	76%	6%	18%
All medical staff	65%	5%	30%

Source: Department of Health annual workforce census 2003

The Department of Health has introduced a strengthened ethical recruitment policy for NHS employers, which stipulates that NHS trusts should not actively recruit from developing countries, unless there is agreement with the government of the country. Such agreements currently exist with India, China, Pakistan and the Philippines (Department of Health 2004c).

Reliance on international recruits also raises another challenge. In recent years there has been an increased flow of nurses from the United Kingdom to the United States and other English-speaking developed countries (Buchan and Seccombe 2004), suggesting that for some internationally recruited health care workers, the United Kingdom may be a stepping stone to other countries, such as the United States or Canada.

A large proportion of refugees coming to the United Kingdom choose to settle in London, despite dispersal policies to relocate them throughout the country. The Department of Health has allocated funding to projects that encourage the integration of medically trained refugees into the NHS (Department of Health 2003). This has included supporting the British Medical Association (BMA) and the Royal College of Nursing (RCN) to set up databases of refugees and asylum seekers in these professional groups. Over 1,000 refugee doctors are registered on the BMA database. Currently only 7 per cent (69) are practising medicine, with a further 16 per cent (159) being 'job ready' (that is, they have passed the relevant English language exams and have the correct registration) but not currently practising. Initiatives such as arranging clinical placements and study groups for exams have also been supported and have received positive feedback (Fida 2003).

The RCN's refugee database has 228 nurses and midwives registered as of October 2004. Of these, 44 per cent are living in London, 39 per cent are currently unemployed, 48 per cent have been in the United Kingdom between one and three years and 36 per cent are seeking asylum (RCN, personal communication 2004).

London has led the way in engaging with refugee health care workers to enable them to work in the NHS by setting up local initiatives with the deanery (responsible for postgraduate medical training in London), strategic health authorities and primary care trusts (PCTs). However, these rely heavily on the goodwill of a small number of committed clinicians and often have limited funding. Tapping into the skills of these refugee populations and providing the appropriate support to enable entry into employment within the NHS remains a challenge – not just for the Department of Health and the NHS, but also for other government departments and agencies, whose co-ordinated input is required.

Challenge 6: Retaining staff

Retaining NHS staff in London remains a problem owing to the high costs of accommodation. Schemes such as financial assistance for those wishing to buy property and child-care provision may provide some solutions. These help staff cope with the practical difficulties of living in London, and can make staff feel more valued and help to reduce stress levels – factors shown to improve staff retention.

For reasons discussed previously, retaining NHS staff has provided a constant challenge to London for many years. *In Capital Health?* reported that in order to get a 100 per cent mortgage at three times annual income to buy a 'first home' in London, an income of £65,000 would be required. With only limited house price inflation this figure was little changed at December 2004.

A ward sister on a G grade would have an income of about £30,000 if working in an inner-London trust (www.rcn.org.uk). This would enable them to obtain a mortgage of up to £90,000. However, the average Greater London flat/maisonette price reported for December 2004 was £203,500 (www.hometrack.co.uk), well above the means of the majority of first-time buyers on NHS salaries.

Some of the solutions to this problem have been to provide grants or loans to enable 'key workers' to get financial support to buy their own properties. Under the 'Homebuy' scheme, 84 buyers had completed as of August 2004, with a further 312 at 'an advanced stage' (Department of Health 2004d).

The 2001/2002 NHS staff survey in London (Robinson and Perryman 2004) examined the factors that made staff more likely to be planning to leave their current post. These were: being male, being under 30 years old, and working shifts.

Factors that reduced the likelihood of staff planning to leave were: having caring responsibilities, being over 50 years old, long tenure of current post (longer tenure reduces the intention to leave), and working part-time.

The survey found that when all the factors affecting retention are put together, the most important for NHS staff in London were, in rank order:
1. feeling valued and involved
2. equal opportunities and fair treatment
3. length of service
4. stress and work pressure
5. job satisfaction
6. caring responsibilities
7. type of contract (part-time versus full-time).

Child care

One in three NHS staff in London (33 per cent) report having dependant children of under 16 years old at home (Robinson and Perryman 2004). Employers providing or assisting in the co-ordination of child care can make a huge difference to the ability of NHS staff to continue working by lowering stress for the individual. This then reduces staff turnover for the organisation as a whole.

Child care initiatives across south east London have had a noticeable impact and are estimated to have generated savings to the NHS of £23.9 million per annum. This figure is based on the proportion of staff who have indicated that child care support helps them to work in the NHS (59 per cent), and have stayed in their jobs as a result (at King's College Hospital, 11 per cent of staff reported leaving the NHS for child care related reasons on exit interview), using turnover costs equivalent to one year of salary (Finch and Fleming 2004). Eighty-seven per cent of respondents using new child care places said that the NHS child care support had helped them to continue to work for the NHS, and 95 per cent said that it had reduced stress. An expansion of 60 new nursery places to add to an existing 90 places at King's College Hospital in south east London contributed to almost halving vacancy rates from 13.5 per cent to 7.3 per cent, a 4.3 per cent reduction in voluntary turnover rates (that is, staff choosing to leave their post for reasons other than ill health, retirement or dismissal) in nursing and midwifery and a reduction in bank and agency nursing hours (Finch and Fleming 2004).

Challenge 7: Attracting staff back

Return-to-practice and supervised-practice programmes have proved a successful and cost-effective way of attracting health care professionals back to the NHS in London. However, there have been problems in recruiting midwives in particular on to both these programmes.

Attracting staff back to the NHS has been a major strategy to increase the workforce, particularly with nurses, midwives, GPs and AHPs. Supervised-practice programmes (also known as 'adaptation') for health professionals who are registered abroad but live in the United Kingdom and need to undergo a period of supervised practice in order to register their qualification in the United Kingdom have also been established.

Return-to-practice initiatives are now being run for nurses, midwives and AHPs across London. In some Workforce Development Confederations (WDCs), co-ordination of return-to-practice programmes has now been combined with programmes of supervised practice for health care professionals trained abroad. Although there remains a steady stream of interest in return-to-practice programmes, the London-based WDCs report higher demand (although not necessarily provision) for the supervised-practice programme. Some of the WDCs have reported particular problems in recruiting midwives to either supervised-practice programmes or return-to-practice programmes. One reason for this is that programmes for midwives tend to be longer, so those with both a nursing and midwifery qualification may prefer to pursue a nursing programme, which will enable them to get back into paid employment more quickly.

TABLE 4: RETURN-TO-PRACTICE AND SUPERVISED-PRACTICE NURSES AND MIDWIVES IN LONDON, APRIL 2003 TO MARCH 2004

Strategic health authority	Return to practice	Supervised practice	Total
North West London	73	52	125
North East London	50	217	267
North Central London	246	93	339
South East London	42	135	177
South West London	204	15	219
Total	**615**	**512**	**1,127**

Source: London Workforce Development Confederations 2004

There has also been some success reported in return-to-practice programmes for AHPs, although the numbers in the programmes are considerably smaller than those for nursing.

Until 2004, the financing of return-to-practice courses came from the WDCs using ring-fenced monies allocated centrally. From 2004/05 this funding will move into PCTs' core baseline funds and will no longer be ring-fenced (with the exception of return-to-practice for health care scientists and midwives). It will be important for PCTs to support these courses financially since return-to-practice remains one of the most cost-effective means of recruiting staff (Department of Health 2004e).

Challenge 8: Improving the use of temporary staff

Expenditure on temporary staff in London has decreased over the last year, although it still remains high. NHS Professionals, the NHS in-house agency, has helped to bring about this reduction by working in partnership with the London Agency Project. However, trusts that have yet to use NHS Professionals are still experiencing rising costs.

The extent to which the NHS continues to be dependent on the use of temporary staff may provide another indicator of persistent shortages. The effective management of temporary staff is a critical factor in containing costs within the NHS, as temporary staff are more expensive to employ. There are situations in which the use of bank, agency and other flexible staff can be effective, such as the short-term cover of absent permanent staff, but long-term or high-level use of agency staff can be costly, and may reflect an inability of organisations to recruit permanent staff.

In Capital Health? reported that in recent years there has been an increasing trend in the annual amount spent on non-NHS employed nurses and midwives. However, the most recent data available suggests that this trend may now be reversing (at least with regard to expenditure on temporary staff employed by agencies and nurse banks). While expenditure on non-NHS employed nurses and midwives almost tripled in London between 1997/98 and 2002/03, unconfirmed figures for the financial year 2003/04 report a reduction of 16 per cent expenditure in London (based on provisional data: Hansard 2004a) compared to an 11 per cent decrease across England (based on unaudited accounts, Hansard 2004b).

The annual expenditure on agency doctors in London increased rapidly in the period between 1997/98 and 2002/03 – tripling from £22 million to £66 million (Hansard 2003).

Across England, the NHS is attempting to bring more of the resourcing of temporary staffing in-house through NHS Professionals, the NHS-run nationwide source of temporary medical, nursing and midwifery staff. NHS Professionals has been working in partnership with the London Agency Project – a procurement agency for the NHS in London – to arrange the supply of temporary nursing, midwifery, health visitor and health care assistant staff, and which is reported to be demonstrating savings on agency spending. However, trusts that have yet to use NHS Professionals but are signed up to the London Agency Project are still experiencing rising costs (NHS Professionals, personal communication 2004).

NHS PROFESSIONALS IN LONDON

- 14,558 staff in its bank.
- 440,289 shifts filled with NHS Professionals staff in the financial year 2003/04.
- 71 per cent of shifts filled by the NHS Professionals London Service Centre from its bank.
- 24 per cent of shifts filled by agency staff.

Source: NHS Professionals 2004

Challenge 9: Planning for an older workforce

With the exception of community and primary care services, the NHS in London has a younger workforce than England as a whole. In autumn 2004, the Department of Health launched a campaign to attract people over 50 to work in the NHS. It is important that initiatives to identify the needs of these older staff are developed in order to retain this group up to their retirement.

The NHS in London generally has a younger hospital workforce than the rest of England. However, within community and primary care services, the age profile of staff is older in London than nationally, with a high proportion of nurses and GPs aged over 50. As many of these staff are likely to retire within the next few years, this represents a great challenge to primary and community care in London. The issue is particularly acute in NHS community services, as these areas tend to attract staff later on in their careers.

Older members of the NHS workforce have different needs to the younger workforce. The NHS will have to work hard to retain staff who may be attracted by the idea of early retirement, or are

fatigued by high stress levels and the pace of change in the NHS. Workplace stress and excessive workload are cited as the main reasons for staff leaving the NHS (Office for Manpower Economics 2003b); older nurses report feeling 'burnt out', citing this as a major reason for making the decision to retire (Meadows 2002).

London has a polarised age profile within its GP workforce. It has a higher proportion of younger GPs than the rest of England, with 17 per cent of London GPs aged under 35, compared with 10 per cent across England as a whole. However, London also has a higher proportion of GPs over 50 years old, with 40 per cent of London GPs over 50 compared with 35 per cent across England. These older GPs are likely to retire in the next ten years. Particular challenges are likely in north east London, where 48 per cent of GPs are over 50 years old, and where there is a relatively small proportion of younger GPs (source, Department of Health NHS workforce census 2003).

In the autumn of 2004, the Department of Health launched a targeted campaign to attract people over 50 to work in the NHS. This is a potentially valuable workforce to the NHS, although it is essential that the appropriate support services are in place for employees choosing to return to work or start work in the NHS later in life. Efforts should also be made to retain NHS staff over 50 by valuing their expertise and experience and encouraging them to remain in the NHS until they retire. Once AfC is implemented, the fact that the London allowance will count as pensionable pay may have an impact on retaining older staff.

So far, many of the staff retention policies (for example, the Improving Working Lives initiatives, which set a model of good human resources practice against which NHS employers will be kitemarked) have focused on the needs of younger staff, addressing issues such as flexible working for those with children. However, it is evident that the needs of older workers, potential older returners, and potential older recruits will have to be fully assessed if the NHS is to effectively tap these age groups for staff.

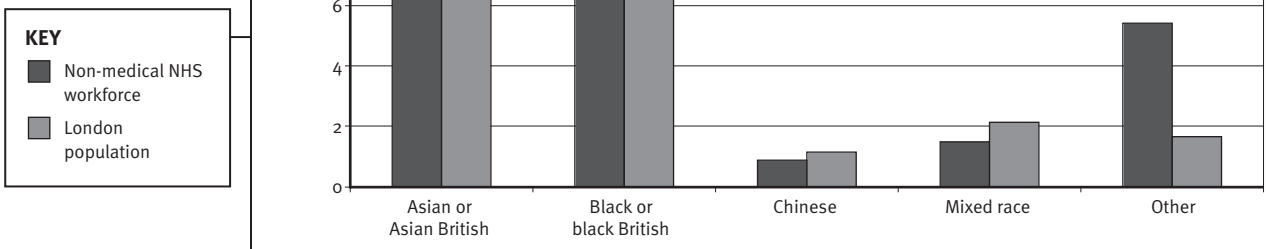
Challenge 10: Ensuring equal opportunities and widening entry routes

Ethnic diversity remains a feature of the NHS workforce in London, but minority ethnic groups are under-represented at senior levels in NHS organisations. Similarly, those from lower socio-economic backgrounds are less likely to be accepted into medical school. However, efforts are being made to widen entry routes into the NHS with initiatives such as nurse cadet schemes, apprenticeships, access-to-medicine courses and graduate entry programmes.

The demography of the NHS workforce has changed overall as well as within different professional groups over the last few years. The London NHS workforce has a higher proportion of minority ethnic groups than the London population as a whole. Department of Health data indicates that 37 per cent of the NHS non-medical workforce in London is from minority ethnic groups compared to 28 per cent of the working age population. Figure 6 (opposite) shows the ethnicity breakdown of the London non-medical NHS workforce compared with the total London population of those in non-white ethnic groups.

Within the registered nurse population there is a higher proportion of those describing themselves as black or black British when compared with the local London population of working age (source, Department of Health, non-medical workforce census 2003). This is similar

6 **MINORITY ETHNIC GROUPS REPRESENTED IN THE NON-MEDICAL NHS WORKFORCE IN LONDON AND IN THE TOTAL LONDON POPULATION OF WORKING AGE (18–65 YEARS)**



Sources: Department of Health 2003, census data 2001
Note: Department of Health data contains 19 per cent in 'unknown' ethnicity category, which have been excluded

to findings from an RCN membership survey, which found that, in London, 35 per cent of nurses came from minority ethnic groups (Ball and Pike 2004). These findings will be partly due to international recruitment, which has attracted a large number of nurses from overseas to work in the United Kingdom, particularly in London. Many of these nurses are from Africa and Asia (particularly the Philippines). However, minority ethnic representation is not constant across all occupations and grades: only 19 per cent of London NHS employees in management posts come from minority ethnic groups compared with 37 per cent of nurses.

Across England, a similar picture emerges in medicine: among lower grades nearly 60 per cent of doctors come from minority ethnic groups, whereas only 21 per cent of consultants are reported to come from ethnic minorities (British Medical Association 2004b). Results of the 2004 survey to monitor NHS equalities and education targets reported that in London between 12 and 29 per cent of executive directors in NHS strategic health authority areas were from minority ethnic groups, compared with 21 to 35 per cent of resident working age populations (Department of Health 2004f). This represents an improvement on previous years but demonstrates that there is still a great deal of work needed to ensure that there is proper representation of minority ethnic groups at all levels of the NHS. It is also important for new staff coming into the NHS at junior levels to have appropriate role models at higher levels of the organisation.

The demography of medical schools gives an indication of how the medical workforce will look in the future. The BMA reports a steady increase in the proportion of women entering medicine, with over 60 per cent of all entrants to medical school now being female. Around 30 per cent of all those accepted to medical school come from minority ethnic backgrounds, of which

two-thirds are Asian. In postgraduate medical training in London, 51 per cent of specialist registrars come from minority ethnic backgrounds. The vast majority of medical students still come from the higher socio-economic classes, and the likelihood of an applicant being accepted to medical school declines with a lower socio-economic background (British Medical Association 2004b).

Widening entry routes

Initiatives to attract potential NHS staff who would not have the required academic qualifications, such as to nurse cadet schemes, have been very popular and over-subscribed (South East London Workforce Development Confederation, personal communication 2004). Apprenticeships within the NHS for trades, such as electricians, have also proved popular, attracting people who perhaps would not have previously considered working in the NHS.

Guy's, King's and St Thomas's medical schools are running an extended six-year medical degree for students from inner London who do not have the actual or predicted grades to get into medical school. The first three years develop at a slower pace, enabling them to get more support early on during the training (King's College London 2004). Other medical schools in London are also running access-to-medicine courses and entry programmes for those already holding a degree to encourage more diversity within the profession.

Looking forward

Where are we now?

Positive developments

Since the publication of *In Capital Health?* in 2003, progress has been made in the following areas.

- Staff numbers have grown in London, as in the rest of England, as promised in the *NHS Plan*.
- Spending on agency nursing staff appears to have reduced. This is encouraging, assuming that temporary and flexible staff are being used more effectively, and that any cost savings are being used to support permanent staff.
- The number of mature students entering professional training has increased. This is likely to be a reflection of the widening of entry routes.
- An increased proportion of applicants for London-based nurse training are resident in London.
- The provision of child care has increased in line with the Improving Working Lives initiative. This appears to be having a real impact in terms of attracting and retaining staff to NHS organisations.
- A stream of qualified professionals has been returning to the NHS, partly as a result of return-to-practice and supervised-practice programmes.

Continuing challenges

Certain issues identified in *In Capital Health?* remain largely unchanged.

- London continues to account for around one-third of all NHS vacancies across England, while making up only 15–20 per cent of the England NHS workforce. This implies that London health care employers are still having to cope with the problems of managing vacancies in a competitive market.
- There continue to be major problems recruiting to the allied health professions (AHPs), particularly at higher grades, although a large group of young AHPs has recently entered the NHS. In order to retain this group, it will be vitally important to support them as they progress in their careers. Given the future emphasis on primary and community care services, it will also be important to train some of these AHPs to take on community-based roles.
- GP vacancy rates are high in the capital, and nearly half of London GPs will be approaching retirement age in the next five to ten years. In addition, there is an increasing proportion of women in training for general practice, many of whom may prefer to work part-time later in their careers. This means that in future London will require more GPs by headcount to cover the capital.

Further challenges

A number of additional workforce challenges are also emerging.

- Some of London's mental health trusts appear to have particular problems recruiting both doctors and nurses, as indicated by high vacancy rates (source, Department of Health vacancy data 2004). Until recently most of the NHS recruitment initiatives have focused primarily on acute hospital care. More work is required to identify and implement interventions that are targeted at both the community and mental health sectors.
- The implementation of chronic disease management initiatives targeted at patients in the community will put increasing pressure on community nursing services, which are already stretched and tend to rely on an older workforce.
- Delivering the NHS reforms that form part of the Agenda for Change (AfC), as well as the various other policy initiatives emerging from the Department of Health, will add to the existing recruitment and retention challenges that face human resources managers within the NHS in London. Developing a longer-term co-ordinated workforce planning and development strategy will be essential if these challenges are to be met.

Ways forward

What can be done at a national level

The major development for the NHS workforce community over the next year is the implementation of AfC. Pilot studies of AfC have revealed a number of issues that need to be resolved at a national level, such as agreeing remuneration rates for unsocial hours in a way that makes these shifts attractive to staff. National policy-makers will also need to deal with any initial implementation issues arising out of AfC that affect the whole of the NHS.

Across the NHS, there is a need for national monitoring to assess the impact of the new consultant contract on hospital trusts, as well as the impacts of the new General Medical Services (GMS) contract and the changes in eligibility for financial incentives, such as 'golden hellos', on the recruitment and retention of GPs.

In the longer term, the NHS needs to develop a strategic approach to workforce planning and development to tackle the following challenges created by recent policies.

- **The shift in care from hospital to community-based services** To manage this process, the NHS needs to develop GPs and nurses with specialist skills who can work within community settings.
- **The establishment of foundation trusts** These are promoted as having greater flexibility in the ways that they can recruit and retain staff, enabling them to design roles around the needs of patients and the service requirements. However, this flexibility is untested; they will also have to cope with increases in the staff wage bill as a result of AfC and the new consultant contract, which may undermine their ability to meet financial targets.
- **Changes in patterns of service delivery** Initiatives such as the use of private sector diagnostic and treatment centres will require specialist trained staff who have traditionally worked in NHS hospital settings to adapt to working in community settings within the private sector.

- **The implementation of chronic disease management initiatives** This will lead to an increase in the provision of high-intensity community-based nursing for older people and those with long-term conditions. There is a target to recruit 3,000 community matrons across England to undertake this role.
- **The implementation of the Modernising Medical Careers initiative** This will change the way and speed at which doctors are trained as specialists, enabling the NHS to train more consultants more quickly to meet the demands of the health service.
- **The reduction in junior doctors' working hours** This was necessary in order to comply with the EU Working Time Directive, implemented in 2004. As a result, the NHS now requires more junior doctors to meet demand for out-of-hours medical support in hospital settings.
- **The wider development and implementation of new roles within the NHS** This is necessary in order to meet some of the challenges brought about by recent health care reforms. Some roles will be expanded to incorporate additional responsibilities, such as prescribing, while others, such as surgical practitioners and community matrons, will be entirely new. The NHS needs to develop training and development programmes for health care workers in order to fill these roles.

What can London do?

During 2005, the critical challenge for human resources in the London NHS will be to achieve the national agenda within the dynamic labour market of the capital. The following strategies will help to manage this process.

- **Enabling staff to move between acute and primary and community care services** The shift in focus from hospital-based services to community and primary care-based services will present particular problems for London as much of the experienced community nursing and GP population approach retirement during the next five years. To cope with these problems, London needs to develop bespoke training opportunities to enable staff to make the transition from acute to community and primary care services, and to work across the interface at an earlier point in their careers than they would have done in the past. In some parts of London this is already happening with the development of innovative fast track programmes aimed primarily at nursing staff. Whether or not local education providers have the capacity to develop new programmes of training is a key issue in managing this transition.
- **Targeting recruitment campaigns at local minority ethnic groups** London trusts need to promote the NHS in London to Londoners from minority ethnic groups who may not previously have been attracted to the NHS for a career. At a practical level, this may involve engaging with local education and employment services to develop opportunities to market the NHS and encourage apprenticeships and placement opportunities.
- **Supporting new staff with training and development opportunities** London trusts need to focus on supporting new staff coming into the NHS in order to improve staff retention. In particular, they need to ensure that appropriate training and development opportunities are available to those from abroad and minority ethnic groups, enabling these groups to have equal opportunity to gain the skills required for senior NHS posts. This is an area in which London can lead the way, as there is already considerable experience of recruiting staff internationally.

- **Collaborative working between NHS trusts, local authorities and the Greater London Authority** It is important that NHS trusts work in collaboration with local authorities and other employers and the Greater London Authority to find joint solutions to certain broader workforce and labour market issues. These include the provision of affordable accommodation, the provision of local, high-quality, affordable child care, and the resolution of transport issues for NHS staff. Investing in these areas will help to improve retention of staff within the London health economy.
- **Paying attention to local workforce priorities** Many of the new issues on the workforce policy agenda in London are driven by national policy. While these national changes have the potential to support positive developments in London, it is important that those responsible for the NHS workforce in the capital do not lose sight of the other, more local workforce priorities identified in this report.

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Janice Robinson

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