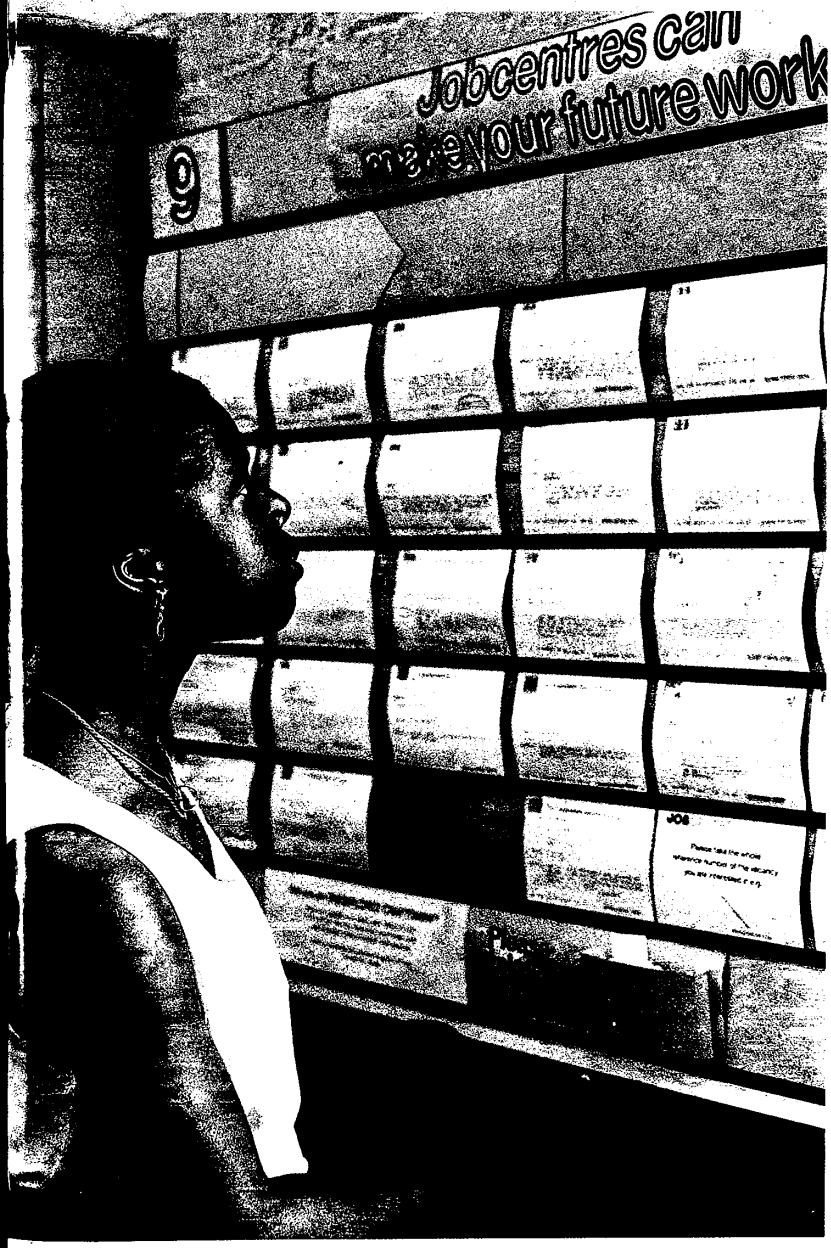
Health Care Labour Markets



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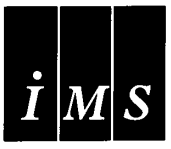
Ian Seccombe
James Buchan



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Executive summary

What is the current health care workforce profile in London?

- The NHS employs 172,000 staff (whole-time equivalents, wte) in London, representing twenty per cent of the NHS total in England. Half the London workforce is employed in nursing and midwifery.

What variations in the profile are there between different areas of London?

- The main variations in the London health care workforce profile cut across its administrative boundaries. Inner London is characterised by a "younger" workforce, more of whom work full time, than the remainder of the capital. Inner London has higher proportions of medical and dental staff and administrative and clerical staff.

How does the London profile differ from the rest of the country?

- Health care staff in London is, on average, younger and more likely to be working full time.
- Health care staff in London exhibits higher turnover rates (often moving between jobs in London). Approximately one in three qualified nurses, therapy professionals and pharmacists moves job every year.
- Three-month vacancy rates for nursing posts in London are four times the national average; vacancy rates for the professions allied to medicine are also more pronounced.
- The use of agency staff is most pronounced in central London.
- In general, the ratio of qualified to unqualified staff is higher in London than elsewhere.

What labour supply constraints exist currently on health care delivery in London?

- Employment indicators show that London experiences difficulties recruiting and retaining health care professionals, particularly those with post-basic qualifications and expertise. Recruitment of non-health specific staff has also been a major problem, because of uncompetitive pay rates; these difficulties have eased recently because of the impact of recession.
- The extent to which labour supply has exerted a significant constraint on health care delivery is difficult to measure. Indicators of delivery

problems, such as ward closures and waiting lists, are often as much the result of a shortage of financial resources, as of human resources.

What are the likely labour market effects of the NHS reforms?

- The NHS reforms, if fully implemented, will create a framework in which responsibility for human resources is devolved and greater "flexibility" encouraged. Wider variation in staffing levels, grade mix and payment systems are the likely end results.
- In the short term, grade mix and staff deployment will be priorities for management in trusts and directly managed units, with specific attention being paid to cost containment. Pay determination, and movement away from national pay bargaining, is unlikely to be the first priority. Predictions that local pay bargaining would lead to an upward pay spiral may be confounded by cartels of employers acting to restrain pay increases.

How will the future shape of the health care workforce differ from the current profile?

- The combination of little increase in met demand for acute services in London, the NHS reforms and pressures for cost containment make it unlikely that there will be a marked increase in the number of health care professionals in London's acute services.
- There is likely to be a greater emphasis on employing health care assistants and other support staff. This would lead to a marked change in the qualified:unqualified staff ratio, and would demand much more effort on the part of employers to recruit and train from local labour markets.
- Cost containment is likely to focus attention on the current high usage of agency staff. In future, more temporary staff are likely to be resourced from internal "banks".
- Contract-based health care provision could lead to provider units employing a greater proportion of their staff – including health care professionals – on timed contracts.

What future supply constraints can be identified?

- General labour market indicators point to an "ageing" workforce in London; the number of school leavers in London will remain below its late 1980s level until well into the next century.
- Despite the predicted change in grade mix, there will be continued difficulty in recruiting and retaining sufficient qualified health care professionals.
- London has traditionally relied on recruiting significant numbers of its young health care professionals from the rest of the country. They have been attracted to the capital by the career opportunities and post-basic training provision in the city. Proposed moves towards regions' self-sufficiency in training, and possible reductions in training provision in the capital, could significantly reduce this inflow.

Abbreviations

DHA	district health authority
FHSA	family health service authority
ICU	intensive care unit
LPAC	London Planning Advisory Committee
MLSO	medical laboratory scientific officer
NAO	National Audit Office
NCVQ	National Council of Vocational Qualifications
ODA	operating department assistant
OPCS	Office of Population, Censuses and Surveys
OT	occupational therapist
PAM	profession allied to medicine
PREP	Post-Registration Education and Practice
RAWP	Resource Allocation Working Party
RHA	regional health authority
SHA	special health authority
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
wte	whole-time equivalent

CHAPTER 1

Introduction: planning for a changing labour market

Background

This working paper examines the London labour market for health care staff. It was prepared by the Institute of Manpower Studies (IMS) as part of the King's Fund London Initiative, established in December 1990 to examine the future of acute health services in London.

This study, which was conducted against the background of the early implementation of the National Health Service and Community Care Act – the NHS reforms – focuses on labour supply and on the extent to which planned or predicted changes in the profile of the acute sector workforce will affect the future delivery of acute services in the capital.

The NHS reforms are likely to have a major impact on the ways in which the NHS employs and deploys its staff. The devolution of managerial responsibility and emphasis on cost control and cost containment, which are major tenets of the reforms, will focus greater management attention on staffing costs and, it is planned, will allow managers to respond more flexibly to their staffing requirements. In particular, those employing units which have successfully applied for self-governing trust status will have the opportunity to implement new working practices, new patterns of employment and new, non-standard, payment and reward systems. This working paper considers the impact of these reforms on employment and deployment in the NHS in London.

Establishing a robust estimate of the future demand for health care in London is outside the remit of this paper. However, the separation of purchaser and provider roles within the health service which came into effect in April 1991 raises the possibility of a major shift in demand for services – and hence for staffing – away from Inner London. Such a shift could lead to financial difficulties, excess capacity and hospital closures in the capital. At present there are substantial net inflows of patients to Inner London. Under the new financing arrangements health service purchasers could have considerable incentives to buy services more cheaply, and locally, than more expensively in Inner London. In the short term most commentators point to a major redistribution of workload away from the high-cost providers in central London. This creates uncertainty over whether the existing pattern of service provision can be maintained. It is therefore particularly difficult to assess the future from our current standpoint. The announcement by the Secretary of State for Health in October 1991 of his intention to establish a review of the London health service – the

Tomlinson Inquiry – and the deferment of trust status for "second-wave" London hospitals underscores this difficulty.

Methodology

It can be quite reasonably argued that there is no "London" labour market for health care staff. Labour market boundaries can be defined according to two key dimensions:

- a geographical dimension – a labour market can be local (the Croydon labour market, for example), regional (the East Anglian labour market), national or even international;
- a dimension related to the characteristics of the people in the labour market: usually these will be occupational characteristics – the labour market for nurses, computer programmers and so on. Other characteristics may also be important – the labour market for part-time staff may have very different contours from that for full-timers.

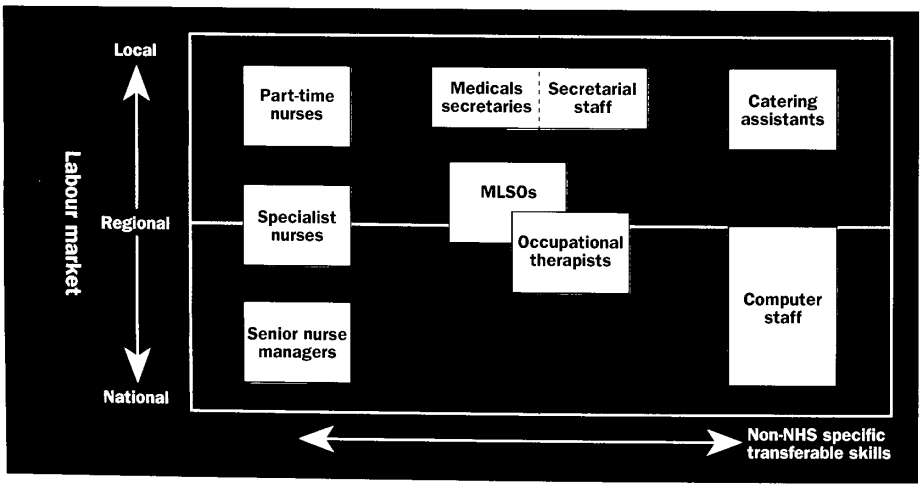
Different types of employee are effectively in different geographical labour markets, and this depends largely on their occupational level in the organisation.

In general terms the higher one goes up an organisation's occupational hierarchy, the wider the geographical labour market one is likely to be operating in. At the bottom of the occupational hierarchy (for example when recruiting to ancillary occupations) employers are usually operating within a purely local labour market – vacancies are advertised locally and recruits tend to be drawn from people who already live within a reasonable daily commuting distance. At the opposite extreme (for example when recruiting into senior managerial posts), the unit is normally operating within at least a regional and more often a national labour market. Vacancies are advertised more widely and recruits may need to relocate to take up their posts.

Our focus is primarily on those staff groups which operate in local and regional labour markets – in particular the nursing and midwifery,

Figure 1.1

Framework for categorising NHS labour markets



Source: IMS

professional and technical, administrative and clerical staff groups. Only limited attention is paid to medical staff who operate in national or international labour markets and who are subject to distinctly differing labour market forces.

The research for this study had two main strands:

- **Primary research**
  The primary fieldwork for the study was based on a set of semi-structured interviews conducted with staff in the personnel functions of the four Thames regional health authorities, in eight district health authorities, two trust-status hospitals and one independent sector organisation. These contextual interviews were conducted in the early summer of 1991; they were selected to give a reasonable spread of views from employers across the regions and covering Inner, Outer and Fringe London.

- **Secondary research**
  The fieldwork data were complemented by a wide range of local labour market and other data and reports, from a variety of published and unpublished sources.

It should be stressed that much of the information used in the study, and presented in this paper, is based on fieldwork with a relatively small number of health care sector employers in London. There is no sense therefore in which the findings presented here can be regarded as being fully representative of workforce characteristics, trends and employment initiatives, in such a large and complex labour market. No attempt is made to present an audit of the London labour market for health care staff.

Clearly, many of the broad figures presented here conceal significant local variations in labour market characteristics and in employment policy and practice. Nevertheless, subject to these qualifications, the information presented here constitutes a reliable overview of the extent and nature of labour supply issues as they currently affect the health care sector in London. For an earlier review of the London labour market – specifically that for nurses – see the *Report of the Review of Nursing Services in London* (NHS, 1988).

Research objectives

The overall objective of this working paper is to present and analyse data on the current profile, recent trends and characteristics of the health care labour market in London, and to use these as bench-marks against which judgements about the future may be made. More specifically the paper sets out explicitly to address the following seven questions:

- What is the current health care workforce profile in London?
- What variations in the profile are there between different areas of London?
- How does the London profile differ from that in the rest of the country?

- What labour supply constraints exist currently on health care delivery in London?
- What are the likely labour market effects of the NHS reforms?
- How will the future shape of the health care workforce differ from the current profile?
- What future labour supply constraints can be identified?

London – a working definition

The planning task in London is complicated by the labour market characteristics of the conurbation and by the fact that there is no single body with the authority to take a London-wide view of the health service. Four different regional health authorities (RHAs) each have a partial responsibility for planning to meet health care needs in the capital; a fifth RHA is responsible for one London "fringe" authority; there are eight special health authorities (SHAs) who manage London's

Figure 1.2

Allocation of district health authorities to London weighting zones by region

	Regional Health Authority				
	North West Thames	North East Thames	South East Thames	South West Thames	Oxford
London Weighting Allowance Zone					
Inner London	Parkside Riverside	Bloomsbury and Islington City and Hackney Hampstead Tower Hamlets	Camberwell, Lewisham and N Southwark West Lambeth	Wandsworth	-
Outer London	Barnet Ealing Harrow Hillingdon Hounslow and Spelthorne	Barking Havering and Brentwood Enfield Haringey Newham Redbridge Waltham Forest	Bexley Bromley Greenwich	Croydon, Kingston and Esher Merton and Sutton Richmond, Twickenham and Roehampton	-
London Fringe	East Herts NW Herts SW Herts	Basildon and Thurrock West Essex	Dartford and Gravesham	East Surrey Mid Surrey NW Surrey SW Surrey W Surrey and NE Hants	East Berks

Source: IMS

postgraduate teaching hospitals. Also, London has eighteen first-wave self-governing NHS trusts.

One effect of this multiple management is that London-wide labour market information is limited in quality, quantity and accessibility. Inevitably, the value of any labour market data decays swiftly. The paucity of current labour market information is a major constraint on this study and on effective manpower planning in the capital.

For the purposes of this paper the Whitley Council definition of "London" has been adopted. The boundaries of Inner London, Outer London and London Fringe follow the London weighting allowance zones. Each of the forty district health authorities has been allocated to one of these zones.

This district structure is in a state of flux. District boundaries are being revised as health authorities merge in response to the NHS reforms. Such mergers will change the composition of the "purchasers" in the London area, and will have a direct effect on employment in purchaser bodies, but could have indirect effects on employment in provider units, depending on the outcome of the tendering process.

Inevitably, labour market boundaries differ significantly from health authority boundaries. An important implication of this when NHS units are devising labour market policies is that the geographical areas within which units compete and where they need to take account of the strategies of other units (and non-NHS employers) may well extend into other health authorities, or even other NHS regions. Many established relationships and networks for thinking about recruitment and personnel issues may therefore be inappropriate for labour market analysis, and labour market strategy formulation.

A guide to the working paper

The remainder of the paper is arranged in five chapters. Chapter 2 describes the major features of the broader London labour market, paying particular attention to the demographic decline. Chapter 3 sets out the numbers and types of staff that presently make up the health care workforce in London and details the extent of staff shortages. The fourth chapter discusses key issues in labour supply to the health care sector. It focuses on competition for labour between employers in the health care sector and between health and other sectors in London. Chapter 5 considers current and future issues of employment in health care in London, looking in particular at aspects of recruitment and retention policy. The concluding chapter discusses future labour supply and demand issues.

CHAPTER 2

The London labour market: components of change

As an employer, the health service probably operates in a greater number and variety of occupational and geographical labour markets than any other organisation. Given its size and diversity, the health service is particularly vulnerable to changes in the external labour market. This fact has been emphasised during the late 1980s and early 1990s, by the well-publicised impact of the demographic "time-bomb" – actually an incremental year-by-year drop in the number of young people entering the labour market (described below). During this period there has been an increasing awareness that the NHS, like other major employers, must give greater attention to the workings of the external labour market when devising its recruitment, retention and reward strategies.

An appreciation of broader labour market issues is important since it influences both the actions and the effectiveness of health care employers in matching the supply of staff with demand. This chapter provides the back-drop against which the labour market issues confronting health care employers will be placed in succeeding chapters. There is a considerable body of literature on the London labour market (see London Research Centre, 1991); no attempt is made to replicate this level of detail here.

This overview focuses on four key trends, which have considerable significance for health care employers in London, namely:

- population change;
- the decline in numbers of young people;
- the continuing shift in employment structure towards services;
- changes in economic activity rates.

Population change in London

There are three demographic trends into the next century that are of importance to health care employers in London:

- the decline in numbers of well-qualified young people;
- a rise in the numbers of people aged between thirty and forty-five, and associated growth in availability of paid employment for women beyond career-break age;
- the growth in numbers of elderly people and its impact on both the demand for health care provision and the supply of labour to meet that provision.

The resident population of London (Figure 2.1) is estimated at 6.76 million (1989), having fallen by 50,000 (0.7 per cent) since the 1981 census. This decline reflects slowing natural growth and rising net losses from London to the rest of the UK. In the late 1980s the rate of this outflow was arrested, largely by lower turnover in the London housing market. Combined with a small rise in natural growth, this resulted in a small population increase – around 21,000 – in 1988-89.

Figure 2.1

Population change in Greater London since 1981

		Population (000s)	**Change** (000s)
Census	1981	6806	-
Estimated	1985	6768	-
	1986	6775	+7
	1987	6770	-5
	1988	6735	-35
	1989	6756	+21
Projected	1991	6806	+50
	1996	6864	+58
	2000	6916	+52

Source: IMS/OPCS

Inner London, which accounts for over a third of the total, experienced a population decline of just under two per cent during the 1980s; Outer London has remained roughly stable at 4.25 million.

The Office of Population Censuses and Surveys (OPCS) forecast an increase in London's population through the early 1990s to 6.86 million by 1996 and 6.92 million by the year 2000. However, the decline in Inner London is expected to continue through the 1990s.

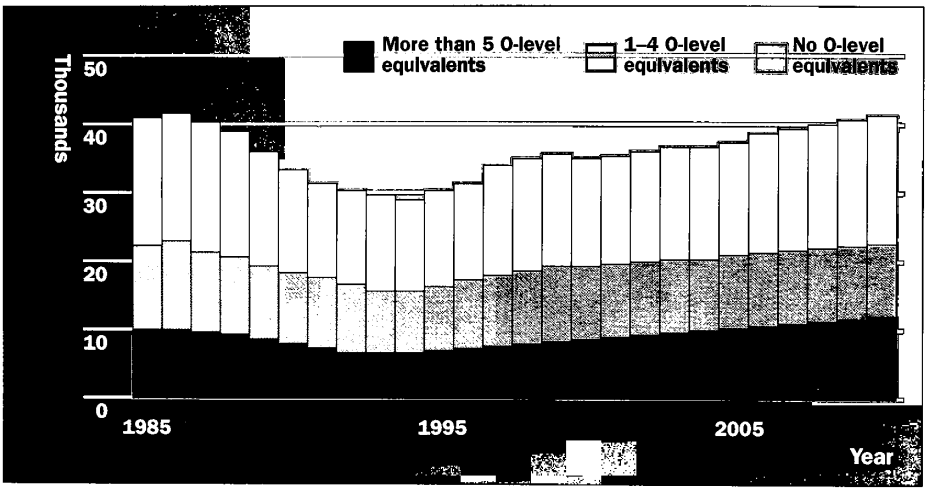
The demographic "time-bomb"

The single most important demographic trend which will affect health care labour markets in London is the future availability of well-qualified school leavers. This is because of the historically strong reliance of many of the NHS professions on drawing large numbers of young people, particularly women, into basic training – especially the nursing and paramedical professions – and accepting high turnover after about five or so years' training and service, as these people leave to take career breaks.

In 1985 about 18,000 young people left school in the Greater London area with at least five higher-grade O-levels but fewer than two A-levels. By the mid-1990s this number is forecast to be only three-quarters of that level. While this trend will affect all professions relying on school leavers, nursing stands out in numerical terms alone. Currently, nursing recruits between a fifth and a quarter of the

Figure 2.2

Qualifications of London school leavers: girls, 1985–2010



Source: IMS

appropriately qualified female school leavers into training. By the mid-1990s the NHS could be attempting to recruit over a third of this total just to compensate for demographic changes.

The overall decline in school-leaver numbers in London is expected to be greater than the national average. This year there will be fewer school leavers coming on to the labour market than last year. There will be even fewer next year and the year after; indeed the decline will not stop until 1994 – when there will be 24,000 (twenty-nine per cent) fewer than in 1985. Even ten years beyond that, in 2004, there will still be fewer school leavers coming on to the market than there were in 1988. Unemployment among school leavers is expected to decline as a consequence; but at the same time there will be increasing competition between those who traditionally recruit among school leavers for the declining pool. This will have far-reaching consequences both for employers and for education and training providers as work, recruitment and training patterns change.

However, variations around the average for London can be substantial – some areas decline by only twenty per cent, while others experience a reduction of more than thirty per cent.

From a labour supply viewpoint what matters about school-leaver numbers is not just the absolute number, but also the proportion who intend to enter further and higher education as against those available for employment. Again, there is widespread variation across London. Six of the local education authorities (LEAs) in London are among the top ten English LEAs in terms of "staying-on rates", with Richmond having the highest rate in England – only forty per cent of school leavers are available for employment compared to an overall figure for London of sixty-nine per cent. In contrast Barking has the lowest staying-on rate – eleven per cent – in England. Nationally, the "staying-on" rate is projected to rise through the 1990s, further restricting the pool of available labour.

Economic activity

A key measure for health service manpower planners is the economic activity rate: that is, the labour force as a percentage of the population of working age. It indicates what proportion of the potential labour force in an area is actually in the labour force at any one time, and it is therefore a key indicator of the size of the "untapped" labour pool in the area.

At 79.5 per cent, economic activity rates in London are similar to the national average (79.3 per cent), although slightly lower than the rest of the South East. This figure is projected to increase only slightly during the 1990s, rising to 80.8 per cent by the year 2000.

For most NHS occupations it is of course the female participation rate which is most pertinent. In the economy as a whole, female economic activity rates have been rising rapidly, mainly as a result of women taking less time out of the labour force for maternity and child-care reasons. On average, the proportion of women in the labour force has been growing at around half a per cent a year. At 69.8 per cent, the female activity rate in London is slightly below the national average (70.5 per cent) and substantially lower than that for the rest of south-east England (73.6 per cent). In part this lower activity rate reflects the lower availability of part-time employment in London – sixty-nine per cent of women work full-time in London compared to fifty-eight per cent nationally.

There are likely to be three major influences over womens' labour force participation in the 1990s:

- fertility patterns – the age at which women have their first child has been rising for some years;
- career break patterns – the length of career breaks has been reducing and is strongly influenced by household income, availability of child-care facilities and the supply of part-time jobs. The ageing population will add to the pressure for career breaks and flexible employment options to care for dependent relatives;
- changing technology and working structures – new opportunities for some women with caring responsibilities may come through moves towards distance working. Some new technologies and the shift towards knowledge-based jobs offer the potential for greater flexibility over the timing and location of work.

Employment Department forecasts are that the female activity rate in London will rise to 73.3 per cent by the year 2000. At the same time, male activity rates in London are forecast to fall, marginally, from 88.4 per cent to 87.8 per cent.

The number of women in the London labour force is predicted to rise by just under five per cent during the 1990s – to 1.56 million in 2000 – compared to a fall of two per cent in the number of men. That is, 73,000 women are projected to join the labour force during the 1990s, whereas the number of men is expected to fall by 40,000. The growth of part-time employment – a key feature of the last decade –

is expected to continue, while at the same time full-time male employment will reduce further.

With the decline in suitable school leavers many different kinds of employer will be attempting to attract this pool of women into the workforce. For the NHS to attract such potential employees, continued improvement in the provision of facilities and conditions which help match domestic commitments with working life must be offered – to current employees to improve retention, to former employees to enhance the ability to return to work, and to potential new mature entrants to training. Moreover, the conditions on offer will need to exceed those offered by competing employers. These are key issues which will be explored in Chapters 4 and 5 of this working paper.

Unless economic activity rates change to a greater extent than currently forecast, it is clear that no significant increases in London's resident labour supply will be forthcoming. Employers with rising labour demand will therefore increasingly be forced to attract more labour from outside London or to adopt strategies which make better use of their existing workforce or which tap into the reservoir of the unemployed and economically inactive.

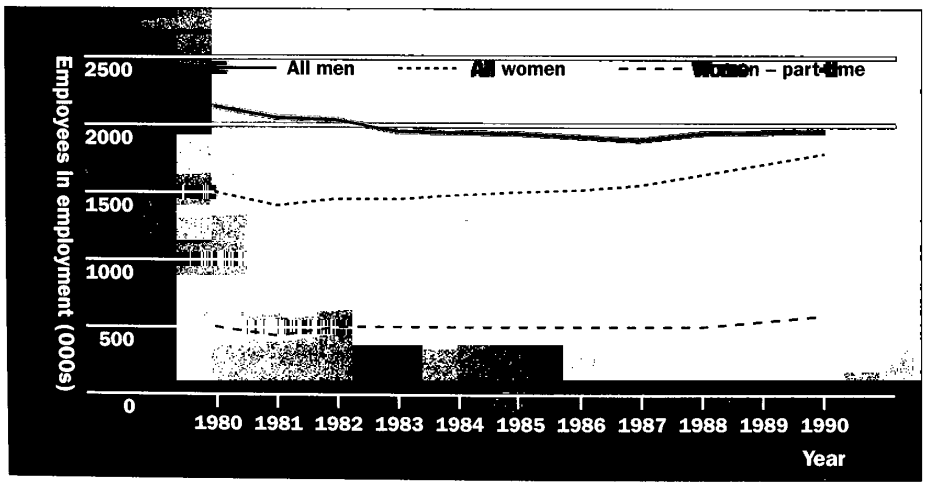
Employment in London

Employment in London grew from 3.66 million in 1980 to 3.75 million in 1990, an increase of just over two per cent. Most of that increase came in the second half of the 1980s. There was a marked slowing in growth during 1990, and rapidly rising unemployment since then has reduced total employment.

Most of the growth during the 1980s was in the employment of women – which rose eighteen per cent in the decade to June 1990. Over the decade the rate of growth in full-time women's employment outstripped that for part-time, although this pattern was reversed towards the end of the decade. The 1980s also saw an eight per cent drop in male employment.

Figure 2.3

Employment change in London, 1980–90



Source: IMS/DE

Fundamental shifts in the structure of employment in London have occurred over the last ten years. This shift is characterised by the changing balance between the manufacturing and the service sector. London's manufacturing industries lost over 150,000 jobs in the period 1985-90, particularly from the metal and chemical industries and the metal goods, engineering and vehicle sector. Indeed, the rate of job loss in manufacturing in London exceeded that elsewhere in the country. In contrast, employment in banking, finance, insurance and business services grew by forty-seven per cent between 1985 and 1990. Employment in the retail sector, in public administration, education, health and other services also increased strongly.

Employment change in the 1990s

Growth in London slowed markedly in the first half of 1990, and the workforce reduced by 37,000, just under one per cent, between June 1989 and June 1990. In the second half of 1990 some 49,000 jobs (1.4 per cent) were lost in London. It appears that London has been affected more sharply by recession than the rest of the South East, where employment has declined by half a per cent over the same six-month period.

Having fallen by around 70,000 in 1988 and by 79,000 in the twelve months to April 1989 (to 224,000) the latest unemployment figures put the number out of work in London at over 361,000 in August 1991, some 8.6 per cent of the workforce, an increase of almost 145,000 since April 1990. More than forty-two per cent of the unemployed have been out of work for more than six months. The growth in unemployment among younger workers has been faster than for any other group, and some twenty-seven per cent of the unemployed are aged under twenty-four.

It is unclear to what extent the current recession will invalidate available estimates of employment growth for London. Recent published work providing long-term employment prospects which date

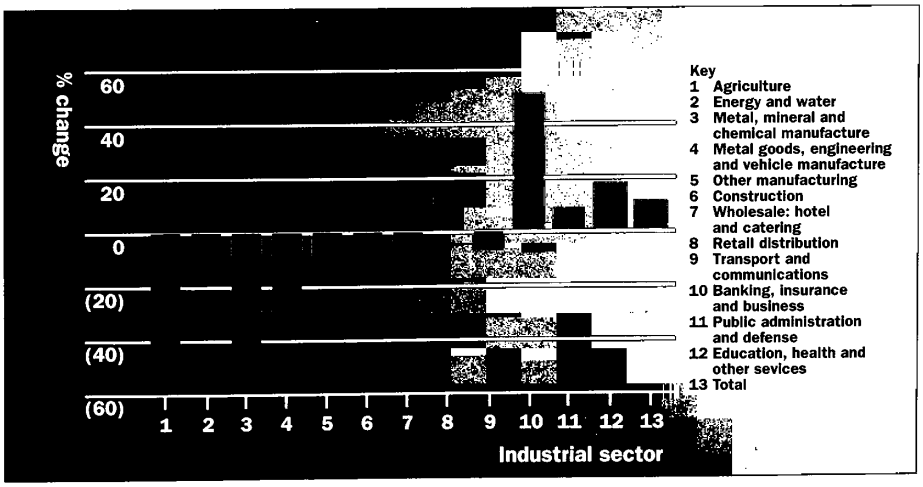


Figure 2.4

London: percentage change in employment, 1985–90

Source: IMS/ED

from 1989 and early 1990 now appears improbably optimistic.

However, while the timing and rate of forecast employment change may be inaccurate, the direction of change remains clear. The general point which emerges from the available studies is that, in the long term, employment within traditionally male sectors of the London economy, notably manufacturing, construction, transport and communications, is declining. The current recession and the industrial restructuring implications of the Single European Market in 1992 reinforce the anticipated trend. The other main feature of the projections is a continued growth in the service sector – particularly banking and financial services – which now dominates London's economy and labour market.

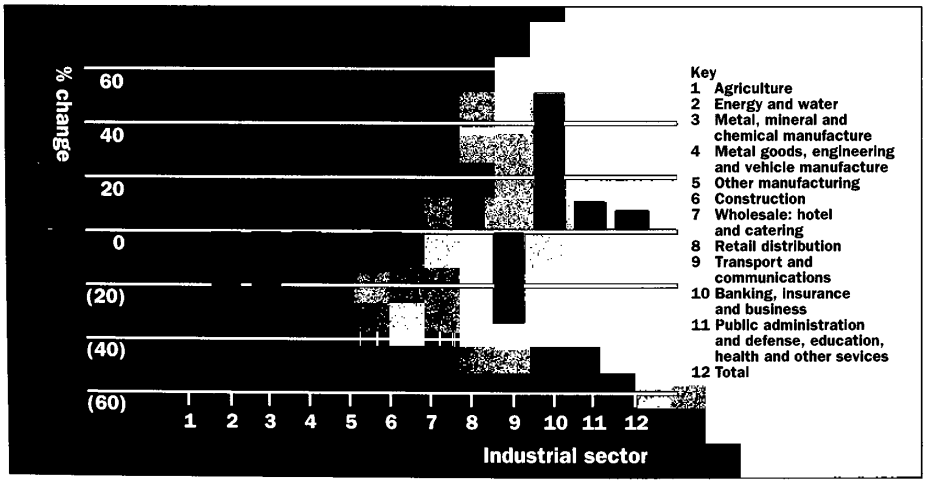
Projections of employment growth by sector compiled by the London Planning Advisory Committee (LPAC) give a maximum net growth in London's employment as 16,000 jobs a year, bringing total employment to 3.7 million by 2001 (LPAC, 1988). In their worst-case scenario LPAC project a decline in employment to 3.3 million.

Even under the most favourable projection, there would be no increase in the number of full-time jobs, and the overall increase masks a drop of 60,000 in male employment as manufacturing and other production sectors reduce to well under ten per cent of total employment by 2001. LPAC estimate that banking, insurance and finance will have overtaken the public sector – where employment is expected to remain constant – as the largest source of employment in London by 2001.

The growth occupations are managerial, professional and technical – by 1996 nearly three-quarters of the labour force will be in these and other non-manual occupational groups. Within the NHS the professional and technical occupations are largely female-dominated. This is not the case in the labour market as a whole. Labour force projections suggest that employers will not find sufficient males to fill these growing "high-level" jobs, and are thus likely to try to attract women looking to participate increasingly in paid employment. Since

Figure 2.5

London: forecast employment change, 1991–2001



Source: IMS/LPAC

the majority of health care employees are female, it follows that the future will see increased competition for the available pools of female employees within the labour market.

The relaxing of labour market pressures as unemployment increases through 1991 will reduce the incentive for employers to construct recruitment and retention packages which benefit employees; and the groups which were targeted by some employers as a means of easing recruitment difficulties during the late 1980s – women returners, older workers, ethnic minorities – may not see the job opportunities in the timescale previously forecast. To some extent, health care employers in London have benefited from the labour market impact of recession – for example, through lower staff turnover. But this is a windfall gain, and it should not be allowed to divert attention from broader long-term demographic and labour market indicators.

Summary

This chapter has summarised some of the key characteristics of, and trends in, the London labour market. London's workforce by the end of the 1990s will be substantially different from that in the 1980s. The number of school leavers directly entering employment will decline significantly. Much of the increase in employment will occur in the service sector, and most will be accounted for by increased female participation in employment. Employer responses to the labour market conditions of the 1990s and beyond will be primarily dictated by the extent to which they have been traditionally reliant on school leavers as the major or sole source of new recruits. Responses will also be dependent upon the ability and motivation of employers to develop non-traditional sources of recruitment, to improve retention and to achieve a more efficient deployment of staff.

The salient points of particular concern to employers in the health care sector are as follows.

- There will be nearly 24,000 fewer school leavers in 1994 than in 1985.
- Over thirty per cent of school leavers in London go into higher and further education. This staying-on rate is expected to rise.
- London's resident labour force is expected to increase by less than one per cent during the 1990s.
- The scope for further increase in female economic activity rates is considerably less in London than elsewhere.
- The recent growth in female employment is primarily the result of the shift in the industrial structure towards industries, especially in the service sector, with high densities of female employment. This shift is projected to continue.
- Part-time employment is comparatively low in London, particularly in central London.

- Rising unemployment during 1991 will relax the pressures caused by the demographic change and rapid employment growth of recent years, reducing incentives for employers to target recruitment at historically disadvantaged groups – women returners, older workers and ethnic minority groups.

CHAPTER 3

London's health care workforce in the 1990s

The health service is one of the largest employers in London. In this chapter we set out to determine how many people are working in London's health care sector at the start of the 1990s. Later (Chapter 6) we shall speculate on the future demand for acute services and the factors likely to influence staffing requirements.

Much of the discussion about health care labour markets in the late 1980s took it as read that labour shortages exist in the NHS. For example, the majority of health authorities surveyed by IMS in 1989 (Meager and Buchan, 1989) reported recruitment difficulties for many different types of staff. This chapter also examines the extent to which staff shortages have persisted into the 1990s in London despite the recession.

Traditionally the NHS has used temporary workers, particularly agency staff, to meet staff shortfalls. The last section of this chapter examines the use of agency staff in London.

The NHS workforce in London

At the beginning of the 1990s the NHS workforce in London numbers some 172,000 whole-time equivalents (wte), representing just under a quarter of the NHS workforce in England. Note that these figures exclude those who are not directly employed by the NHS, for example agency staff (see below) and those employed in the independent sector, for whom no London-specific data exist.

The four Thames regions employ approximately 219,500 (wte), of whom about three-quarters (162,000) are working in districts within the London weighting zones. A further 10,000 (wte) staff are employed by the eight London postgraduate teaching hospitals (special health authorities).

More than two in five (73,250) NHS employees in London work in Inner London, with a little over a third in Outer London. One in five work in London Fringe districts.

Nursing and midwifery staff account for half (86,000 wte) of all NHS health care staff in London. Administrative and clerical staff are the second largest group, representing seventeen per cent of the total.

London has a different staff mix compared with the rest of England. London districts, particularly those in Inner London, have relatively larger numbers of staff in the medical and dental, administrative and clerical, and the professional and technical staff groups compared with the rest of England.

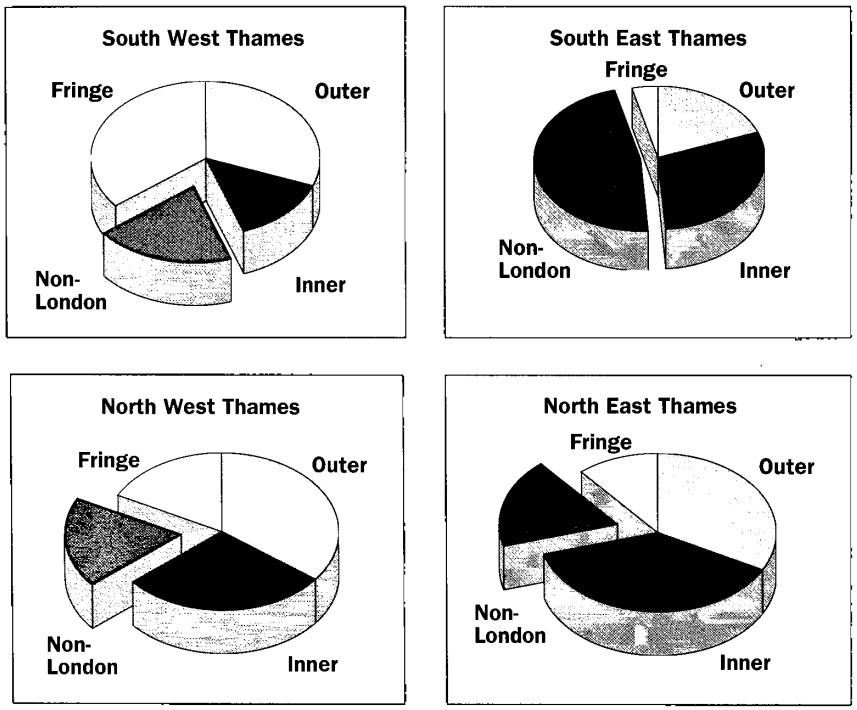
Inner London differs in its staff mix from the rest of London. There

Figure 3.1

Distribution of staff by London weighting zones for each Thames regional health authority

Three of the four Thames regions have eighty per cent or more of their staff working in London districts. The exception is South East Thames, where nearly half the staff are in non-London districts.

The regions also vary in the proportion of staff working in each of the London weighting zones. South West Thames has a markedly different profile from that of the other three regions, with most (thirty-five per cent) of its workforce being in London Fringe districts and the smallest share (fourteen per cent) in Inner London. In the other three regions the largest share of staff is in Inner London districts.



Source: IMS/RHAs

Figure 3.2

NHS employment by staff group and London weighting zone (wte)

Staff Group	Inner London		Outer London		London Fringe		Total		Rest of England	
	Number (000s)	%	Number (000s)	%	Number (000s)	%	Number (000s)	%	Number (000s)	%
Medical and dental	5.4	7.3	3.7	5.8	1.8	5.1	10.9	6.3	30.3	5.5
Nursing and midwifery	32.9	44.7	34.0	53.8	19.1	54.3	86.0	50.0	284.6	51.5
Professional and technical	9.1	12.4	6.3	10.0	3.3	9.4	18.7	10.9	56.7	10.3
Admin. and clerical	14.0	19.0	10.5	16.6	5.2	14.8	29.7	17.3	80.0	14.5
Other	12.2	16.6	8.7	13.8	5.8	16.4	26.7	15.5	100.8	18.2
Total	**73.6**	**100.0**	**63.2**	**100.0**	**35.2**	**100.0**	**172.0**	**100.0**	**552.4**	**100.0**

Source: IMS/RHAs

are proportionately fewer nursing and midwifery staff (forty-five per cent of staff) and more medical and dental and administrative and clerical staff in Inner London. This reflects the central location of three of the four RHA headquarters and the concentration of teaching hospitals.

Staff shortages

Vacancies caused by selective shortages of skilled and professional staff have been with the NHS for a long time. Examples commonly found across the NHS include:

- most of the specialist professional and technical groups;
- IT specialists;
- specialist nursing and midwifery staff (theatre nurses, intensive care units (ICUs), paediatric nurses).

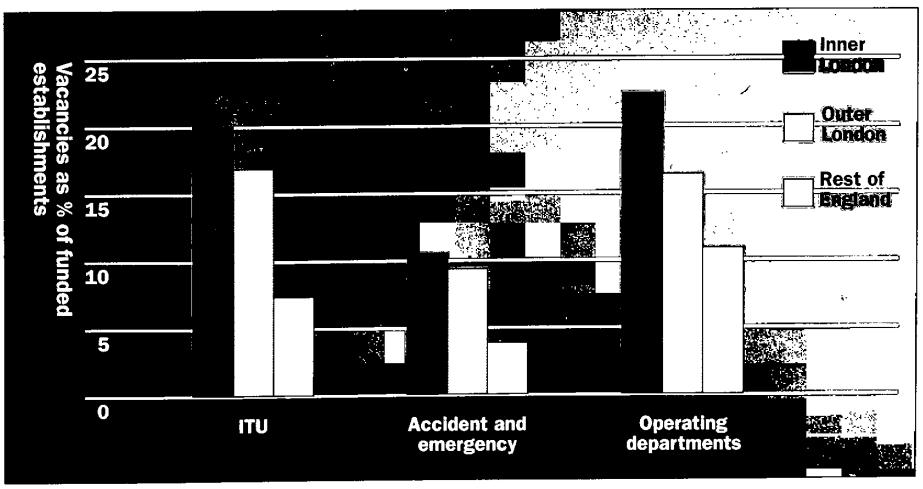
Vacancy rates (that is the shortfall between staff in post and funded establishment) are, however, only an approximate measure of staff shortages. They assume that current funded establishments are correct – if these are too tight for the volume of work to be done, then they will underestimate the extent of shortages. Nor do they take account of *hidden* vacancies (posts filled by under-qualified staff), or *suppressed* vacancies (posts not funded because there is an expectation that they cannot be filled). Little comparative data on vacancy levels exists outside of that presented as evidence to the various pay review bodies. That data has demonstrated consistently higher staff shortages in London than elsewhere in the country.

In 1988 vacancy levels in nursing and midwifery stood at about six per cent for England (excluding London), but at sixteen per cent for Greater London and twenty per cent for Inner London *(NHS, 1988)*. Within these overall rates were some very large vacancies for particular specialities.

At the beginning of the 1990s more than 6500 wte nursing posts

Figure 3.3

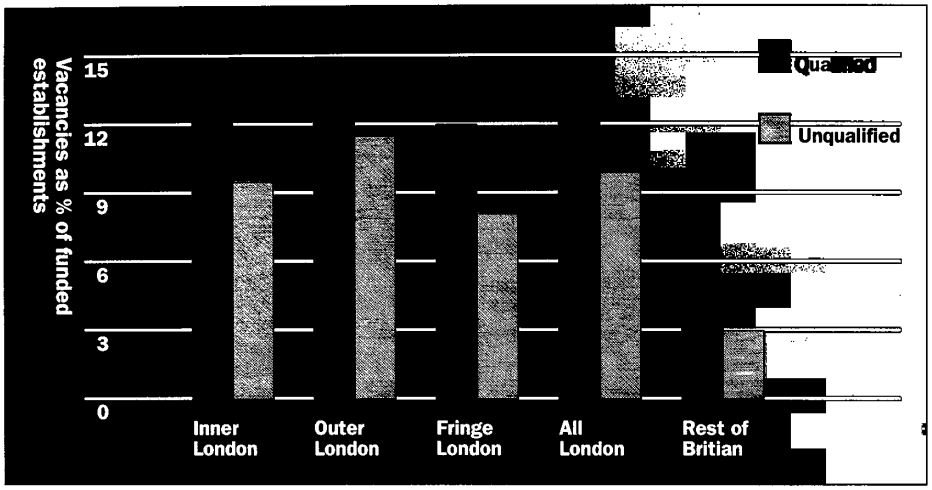
Nursing vacancy rates in high-technology areas



Source: IMS/ DoH Survey of Nurses in High Tech.

Figure 3.4

Vacancy rates for qualified and unqualified nursing staff, 1990



Source: IMS/Review Body

in London were vacant, representing an overall vacancy rate of just under thirteen per cent.

London accounts for more than a third of the nursing posts vacant in Britain at this date. For qualified nurses the vacancy rate in London was more than twice as high as in the rest of the country. Within London the highest vacancy rate is in Inner London at fourteen per cent, compared with thirteen per cent in Outer London and twelve per cent in London Fringe.

The *three-month* vacancy rate for London (nine per cent), regarded by some as a more appropriate measure of qualified staff shortage, is almost four times higher than that for the rest of Britain. The highest vacancy levels are in grade C posts – at thirty-five per cent in Inner London – and in the maternity and paediatric specialities within the acute sector. Moreover, in March 1990 just over half the vacancies in London had remained unfilled for more than six months.

Nationally, vacancy rates for qualified nursing staff were falling in the late 1980s (Review Body, 1991), with the London weighting zones

Figure 3.5

Vacancy rates for professions allied to medicine (PAM), 1990

Source: IMS/Review Body

showing a consistently larger decline. Inner London shows the sharpest fall, from thirteen per cent in March 1989 to ten per cent in March 1990.

The recent decline is partly due to the re-allocation of funding in the wake of the NHS reforms. Despite this reduction, vacancy rates in London remain significantly higher than in the rest of the country. The extent to which this decline reflects changes in funded establishments, and/or improvements in recruitment and retention, is unclear. Interviews conducted at district and unit level in spring 1991 confirmed that vacancy levels had reduced further; nevertheless, all districts continue to report shortages in particular specialities, the most commonly reported examples including theatre nurses, ITU nurses, operating department assistants (ODAs), pharmacists and medical laboratory scientific officers (MLSOs).

Clearly vacancy levels of this kind can have a severe effect on abilities to meet workloads, and localised examples of closed beds and wards have been highly publicised. It also leads to a greater dependence on temporary staff.

Temporary staff

In addition to directly employed staff, the NHS in London makes extensive use of temporary workers, particularly agency nurses. The three *main* reasons for using temporary staff in London have been:

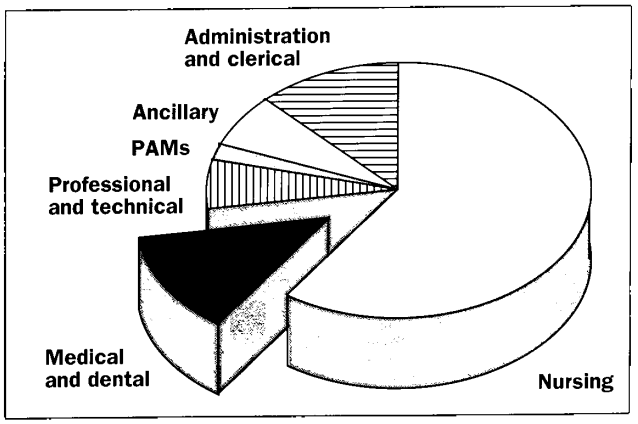
- to cover for recruitment difficulties to the establishment;
- as a cost-efficient way of meeting short-term fluctuations in workload;
- providing cover for staff on sickness absence and other leave.

Nationally, the use of agency staff is concentrated in London, where vacancy rates and sickness absence are comparatively high. With nearly 6000 (wte) nursing staff from agencies, the London region accounted for more than eighty per cent of the national total in 1989 (DoH, 1991).

Figure 3.6

Distribution of agency staff: one Inner London district

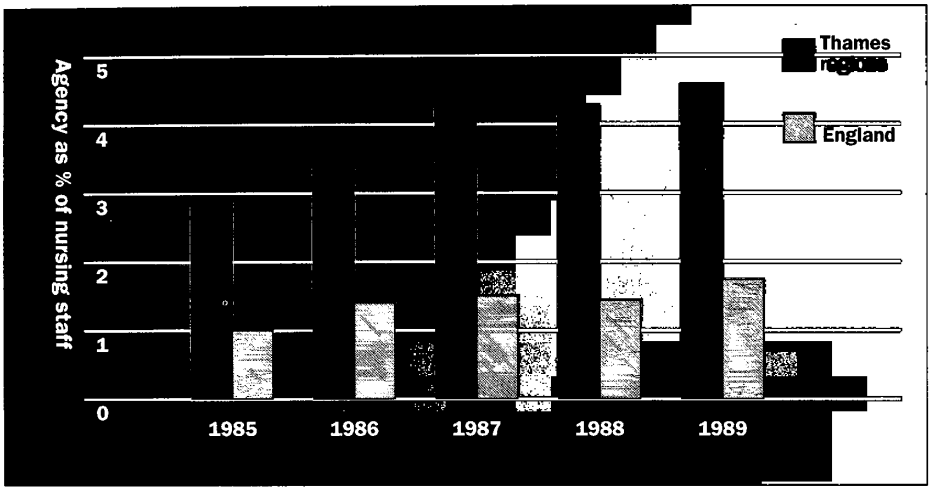
This graph shows the usage of agency staff by staff group in one Inner London district health authority. Two-thirds of agency staff are used in nursing and midwifery, accounting for nearly twelve per cent of unqualified, and eight per cent of qualified, staff hours worked. A further ten per cent are used in administration and clerical work.



Source: IMS

Figure 3.7

Growth in agency nursing: Thames regions and England



Source: IMS/DoH

During the second half of the 1980s the employment of agency nursing staff in the London region grew by around sixty per cent, to account for almost one in every twenty nurses. In some Inner London districts agency staff account for as much as twelve per cent of unqualified, and eight per cent of qualified, staff hours worked.

The National Audit Office (NAO) has reported that most administrative and clerical agency staff usage occurs in London, with two Inner London districts, Bloomsbury and Riverside, spending more than twenty-two per cent (£3.5 million) of total administration and clerical costs on agency staff in 1988-89. In contrast seventy-eight per cent of district health authorities in England spend less than five per cent of such costs on agency staff (NAO, 1991).

Cost constraint requirements have forced many acute service managers to critically examine their use of agency staff in the early 1990s. Use of agency staff has declined, aided by sharply reduced labour turnover as a result of changing labour market conditions. Figures for 1990 show a drop of twenty per cent in the number of agency staff (wte) in the Thames (plus SHA) regions.

The emphases on cost control and containment which are central to the NHS reforms will focus greater managerial attention on staffing costs. It is likely that the extent of agency staff usage may reduce further

Figure 3.8

Expenditure on agency staff in Inner London hospitals, 1990–91

Staff group	**Expenditure**	
	(£000s)	%
Nursing and midwifery	11.05	49.5
Professional and technical	4.66	20.9
Administrative and clerical	4.25	19.0
Medical and dental	1.32	5.9
Ancillary	1.06	4.7
Total	**22.34**	**100.00**

Source: IMS

as increased efforts are put into alternative means of achieving flexible employment such as part-time working, in-house staff banks and job-sharing.

The use of bank staff – that is, staff paid from the health authorities' payroll – is also more widespread in London. The four Thames regions and London SHAs accounted for nearly forty per cent (2250 wte) of all bank nursing staff used in England in 1989, an increase of forty-two per cent on the number used in 1985. Banks have a number of advantages over the use of agency staff. In particular, set-up and administration costs can be lower than cumulative agency fees, the characteristics and experience of individuals on the bank are known, and banks provide a screening and up-dating route back into an establishment post for those taking career breaks.

CHAPTER 4

Recruitment and retention: the key labour supply issues

In this chapter we look at some of the key supply-side issues which have given rise to the staff shortages identified above. In particular we examine the high levels of staff turnover and competition for staff both within the health care sector and between health and other sectors. We also discuss important changes in the organisation of training and the number of entrants to training.

Competing employers

A perennial issue for the health care sector in London has been the high level of staff turnover. High rates of turnover may destabilise work groups, may have an adverse effect on staff morale and may ultimately have a negative effect on the quality of patient care. The cost of replacing leavers can be significant, in terms of the direct and indirect use of resources, and may be problematic if there are shortages of suitable replacements.

The actual (net) costs associated with the turnover of a grade E staff nurse in one London hospital in 1991 were in excess of £4000 (Figure 4.1).

The high level of staff turnover in London reflects the extent of competitive demand for health care occupations. Several forms of competition can be identified:

- competition within the NHS – between specialities, hospitals and neighbouring districts;
- competition with other public sector employers requiring health care skills – for example, family health service authorities (FHSAs) and GPs, local government, the armed forces;
- competition from private health care – acute hospitals, private nursing homes and agencies/locums;
- competition from employers outside health care – for non-specific skills (for example, management, computing, accountancy, clerical);
- emigration – those moving overseas are lost, permanently or temporarily, to the health care sector in the UK;
- retirement – largely permanent loss from the labour market;
- career breaks – one of the largest outflows from female-dominated occupations in the NHS.

Figure 4.1

Turnover costs: staff nurse (grade E)

	£
Separation costs	143
Temporary replacement costs (net)	866
Recruitment/selection costs	830
Induction/training costs	2291
Total	4130

Source: Buchan and Seccombe, 1991b

The question of measuring staff flows is fraught with difficulty in the NHS. The main problem is differentiating between what constitutes *turnover* – where a member of staff may move from one NHS job to another – and what is true *wastage* – where the employee leaves the NHS altogether. In the context of this paper, wastage includes those leavers who remain in the NHS but move to a non-London district.

Most importantly, for effective manpower planning policies to be adopted regarding recruitment, retention and return, it is essential to know where payroll leavers are going, since the likelihood of a leaver returning to work in the future is related to whether they leave the local labour market or not, whether they leave to take up another job outside the NHS or move to another NHS post, whether they leave to raise a family and so on.

Competition within the NHS

Neighbouring health authorities and even hospitals, especially those which straddle common travel-to-work routes, compete with one another for many types of staff. Clearly, there are particular problems for units at the boundaries of the London weighting zones – the effects of travel-to-work patterns, combined with access to differential London pay enhancements, are of fundamental importance in determining the extent of local competition.

Existing organisational structures in London are such that available data seldom permits us to analyse staff losses at this level, since an unknown proportion of those recorded as leavers are moving from one Thames region to another or moving from a London to a non-London district within the same region.

Survey evidence shows that in the last year one in three qualified nurses in London changed jobs, compared to the national figure of nearly one in four (Buchan and Seccombe, 1991a). Most of this turnover involved moves between jobs within the NHS. Inner

Figure 4.2

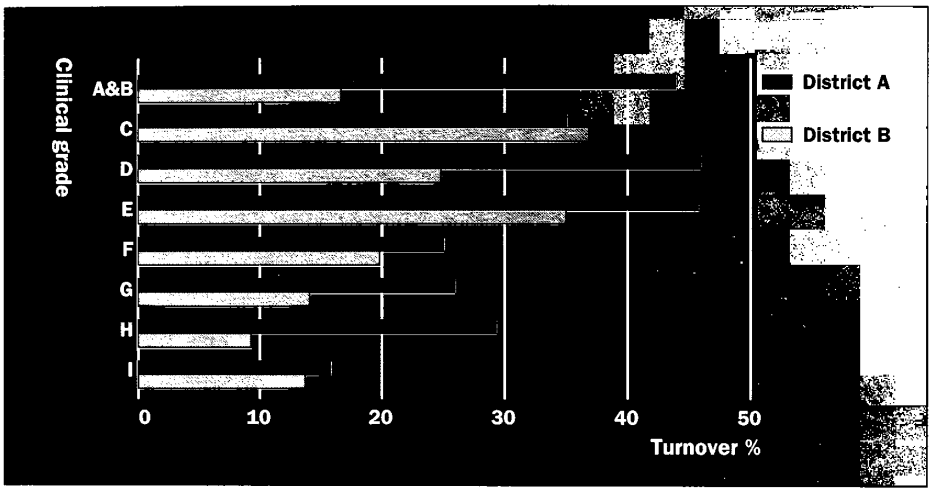
Nursing and midwifery staff turnover rates (%) by district, 1987–88 and 1989–90

	1987–88	1989–90
Inner London		
Wandsworth	25.5	23.5
Outer London		
Croydon	20.2	15.6
Kingston and Esher	22.7	19.9
Richmond, Twickenham and Roehampton	33.0	22.8
Merton and Sutton	23.6	23.1
London Fringe		
NW Surrey	27.8	15.5
West Surrey	30.4	25.7
Mid Surrey	22.3	18.6
East Surrey	17.4	21.4

Source: SWTRHA

Figure 4.3

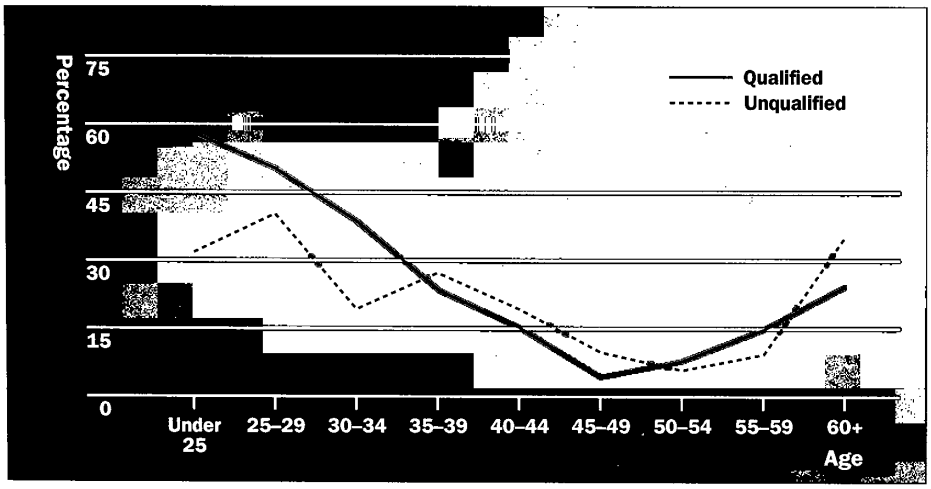
Nursing and midwifery staff turnover by grade: two Inner London districts, 1990



Source: IMS/DHA

Figure 4.4

Nursing and midwifery staff turnover by age: one Inner London district, 1990



Source: IMS/DHA

London has by far the fastest rate of turnover, with over forty per cent of qualified nurses changing jobs, the majority moving between districts within the NHS.

Annual wastage from the NHS in London is estimated at about one in eight, twice as high as in the rest of the country. The level of job mobility in London, as elsewhere, has declined since the late 1980s. Nevertheless it remains comparatively higher than in the rest of the country.

Turnover is highest amongst young staff with short length of service. For example, some Inner London districts recorded turnover rates of up to fifty per cent for nurses under thirty in the main clinical grades (D and E); similarly, around forty-five per cent of physiotherapy leavers from Inner London districts in 1990 had a length of service of one year or less. While young staff are attracted to Inner London, particularly for training, there is a high rate of turnover in the basic grades within a short time of completing training and initial practice.

Figure 4.5

PAMs: turnover by profession, 1990

	Chiropody	Dietetics	Occupational therapy	Orthoptics	Physio-therapy	Diagnostic radiography	Speech therapy
Inner London	-	15.3	47.0	-	30.9	15.3	19.8
Outer London	14.7	30.6	57.3	11.0	25.6	24.8	15.8
London Fringe	19.2	27.6	53.5	15.6	15.6	22.7	22.0
All London	**21.0**	**27.4**	**59.0**	**12.4**	**25.9**	**23.8**	**20.8**

Source: IMS/JNPMI

Turnover rates among other staff groups are similarly higher. For example thirty per cent of qualified PAMs left posts in London in 1989-90 compared with the national figure of eighteen per cent. Again, job changes within the NHS account for much (forty per cent) of the turnover, with about a fifth involving moves out of London.

Public sector competition

The NHS in London also competes with other public sector employers in health care. For example, changes in the organisation of family practitioner services are leading to a rise in the number of practice nurses, and it is likely that practices will begin to employ individual practitioners from within the professions allied to medicine (PAM) and related therapy professions. The growing emphasis on health promotion and primary care, the introduction of the GP contract, and the proposals for limited nurse prescribing, all point to a further extension in the role and number of practice nurses. Given the existing shortages in London, this additional employment source may pose a real threat to labour supply in the acute sector.

The London labour market for occupational therapists is also distinctly asymmetrical – OTs are typically trained within the NHS but subsequently flow from the NHS to local authority employment. Data for one Thames region shows that in 1990 just over one in ten qualified OTs left to take up local authority employment. With increasing provision for care in the community such flows are likely to grow.

Private sector

In the early 1980s private health care employers were insignificant as competitors except in specific locations where, for example, a large private acute hospital was situated. Nationally, private acute beds represented only about two per cent of all acute beds. NHS employers made little use of agencies or locums. In the 1990s, by contrast, private health care provision represents an increasingly important source of competition for staff, and agency/locum employment has soared. The number of

nursing staff employed by the private sector has grown to more than twelve per cent of the national total. Much of this growth has been in unqualified nursing staff – reflecting the large growth during the 1980s in the number of private nursing homes for the elderly.

Significantly, over half the private acute bed stock and thirty-six out of the 130 independent acute hospitals in England are in the Greater London area, where as much as one in four cold surgery procedures are now carried out in the private sector, compared with around one in five nationally (NAO, 1989). In 1986, there were over 6000 (wte) qualified nurses in the private sector in London – excluding those working for agencies (NHS, 1988). This number continued to grow during the late 1980s, in line with the national trend.

Recent surveys have shown that the flow of qualified nurses to the private sector is nearly twice the rate of return from the private sector to the NHS and is higher than average in the Thames regions (Buchan and Seccombe, 1991a). Although the overall net annual loss from NHS hospitals represents less than one per cent of qualified nurse employees, the flow of some specialist qualified nurses (for example, ITU, theatre) represents a far higher percentage loss.

Non-health care sector

Many of the occupations within the NHS which are not specifically health-providing professions are of course prey to competitive demand from non-health employers seeking their skills. This is particularly the case in a highly competitive labour market such as London. For example, in the labour market for medical secretaries there is an asymmetry which operates to the disadvantage of health employers. When appointing medical secretaries, the NHS is recruiting from a

Figure 4.6

Administrative and clerical staff turnover rates (%) by district, 1987–88 and 1989–90

	1987–88	1989–90
Inner London		
Wandsworth	28.7	23.1
Outer London		
Croydon	30.4	21.6
Kingston and Esher	37.5	24.0
Richmond, Twickenham and Roehampton	34.3	29.0
Merton and Sutton	27.4	19.4
London Fringe		
NW Surrey	32.1	20.8
West Surrey	31.1	28.5
SW Surrey	41.0	26.4
Mid Surrey	27.4	19.4
East Surrey	28.0	29.9

Source: SWTRHA

particular part of the wider secretarial labour market, typically the better-qualified end of the market with specialist training, and the recruitment pool is relatively small. Medical secretaries, however, are potential recruits to virtually any secretarial post outside the NHS.

In its recent study *National Health Service Administrative and Clerical Manpower* the NAO found that the highest rates of *turnover* were occurring among administrative and clerical staff in south-east England, ranging from twenty-seven per cent in South East Thames RHA to thirty-two per cent in North West Thames. More recently, turnover rates have fallen sharply as recruitment in other sectors – notably banking and finance – has reduced.

Other non-specific NHS functions – notably finance and personnel – also face stiff labour market competition. The NHS is a small player in the market for qualified accountants, and some districts and units have faced difficulty in filling new posts for qualified accountants and technicians created in 1989–90 and 1990–91. For the most part, the NHS has benefited from the recession, with recruitment by other sectors falling.

The NHS hospital pharmacy service in London faces a similar challenge from the private sector – in particular from pharmaceutical companies and retail organisations. In 1989-90 almost half the qualified pharmacists in London changed jobs – with one in five leavers taking jobs outside the NHS.

Emigration

There is little data available on staff flows from the UK. However, the number of verification documents issued by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) to nurses wishing to work abroad has more than doubled since the mid-1980s. In 1989–90 the UKCC issued over 6700 verifications to non-EC authorities and 400 under EC directives, in respect of UK-based and registered nurses wishing to work abroad. This represents an outflow of around 7000 nurses, approximately one per cent of the stock and more than twice the number of overseas nurses coming into the UK (Buchan, 1991). To date, Europe has been largely irrelevant in this flow.

The majority of those going abroad are destined for North America, Australia and Canada. Although there is no published data on the geographical origin of those now working abroad, it is generally inferred that London, which hosts a large number of overseas recruitment agencies, is more vulnerable to this outflow.

Retirements

With attention focused on the "young" age profile of health care staff in London and the competitive demand from other employers for health care staff, it is all too easy to lose sight of staff losses through retirements.

Between two-thirds and a half of all the ancillary, maintenance and works staff employed by the NHS in London are aged over forty.

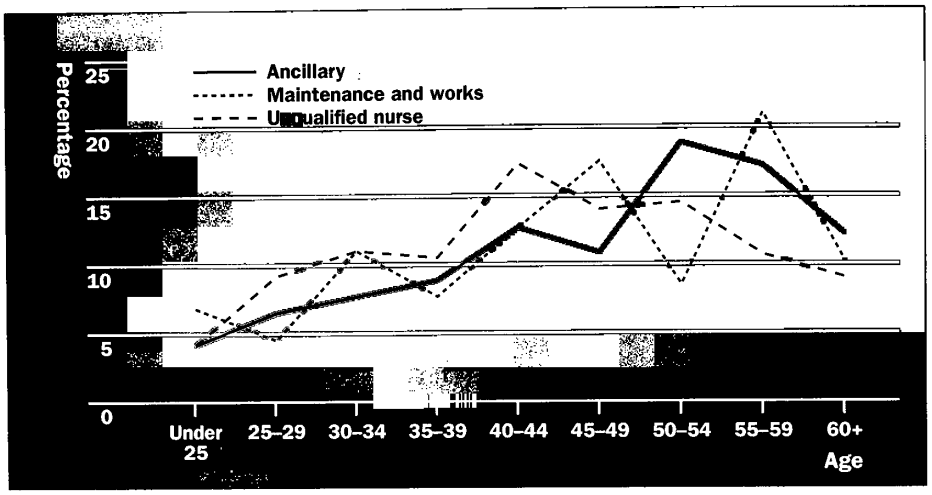


Figure 4.7

Age profiles of unqualified nurses, ancillary, maintenance and works staff: one Inner London district, 1990

Source: IMS/DHA

Historically these staff groups have been recruited in distinctly local labour markets. The next ten years will see increasing numbers of retirements from these grades and a growing recruitment need.

Unqualified nursing staff also have a much older age profile than their qualified counterparts. In some districts, fewer than one in ten unqualified nurses are aged under thirty, while more than two-thirds are over forty-five. Significantly, more than one in five nursing assistants and nursing auxiliaries – whose duties and salaries can be equated with the new health care assistants – are within five years of normal retirement age. The implication of this age profile is that it is difficult to recruit young people into these jobs in London.

Career breaks and labour pools

Conventional definitions of the economically active population are of little relevance to the health sector, where the majority of employees are female. In many cases the largest single category of those holding a professional qualification, but not currently in NHS employment, are those taking a career break to raise a young family. These people are rarely registered as actively seeking work, yet many are in fact predisposed to returning to work once conditions (age of children, costs of child care, hours of work offered etc.) are met. IMS research suggests that nationally more NHS staff leave for career breaks than go to other employment (Waite, Buchan and Thomas, 1989). Those leaving to take a career break can be drawn back into NHS employment in the future, with the offer of:

- retainer arrangements;
- stay-in-touch schemes;
- staff bank;
- refresher courses;

- flexible part-time hours;
- job-share arrangements;
- child-care assistance;
- career opportunities for part-timers etc.

A recent survey of qualified nurses (Buchan and Seccombe, 1991a) revealed that nationally almost one in three respondents expected to take a career break of at least six months during their working life. In Inner London, however, this proportion rose to nearly sixty per cent. This largely reflects the younger age structure of most professional staff groups in central London – for example, more than a quarter of qualified nurses there are aged under twenty-five.

There is little detailed information on the size of the pool of inactive qualified staff from which the NHS could recruit or on the extent of re-entry in London. Among the PAMs, unpublished data from the National Professional Manpower Initiative shows that around six per cent of recruits to posts in London in 1990 were recruited from career breaks, the same value as the national figure. Data for North West Thames RHA shows that this proportion varies widely across the PAM occupations – from around ten per cent for occupational therapists to only two per cent for radiographers. In contrast to nursing, there are few established return-to-work schemes for the PAMs or other staff groups.

The size of the potential nursing pool can be gauged by the number of "ineffective" registrations held by the UKCC for the Thames regions. Ineffective registrations relate to those who retain sufficient interest in nursing to maintain their registration, but who are not currently in practice. In August 1990 the UKCC records show more than 23,000 such registrations in the Thames regions. Over ninety per cent of the ineffective registrants are female and just under half are aged under forty. However, the implementation of the Post-Registration Education and Practice (PREP) recommendations on continuing practice and

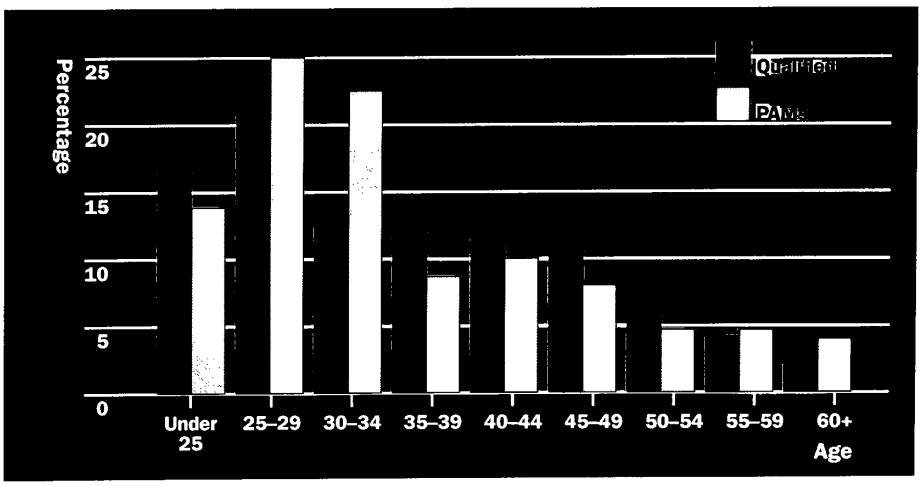


Figure 4.8

Age profiles of qualified nurses and PAMs: one Inner London district, 1990

Source: IMS/DHA

education may reduce this pool to a more representative size. As traditional school-leaver sources of supply decline, it is apparent that health service planners in London will need better information about the pools of labour within their labour market.

Return-to-work schemes for nurses and the availability of nursing banks – used as a halfway house by some returners – are far more developed. A national survey of nurses' career intentions suggests that returns from career break, or from agency or bank nursing, are of particular importance. Survey evidence shows that while the majority of nurses on career breaks expect to return to nursing, they also expect to do so on a part-time basis (Buchan and Seccombe, 1991a).

Part-time working

National statistics reveal an increase of nearly eighteen per cent in the number of women working part-time over the last ten years; in London the figure is sixteen per cent. Within the NHS part-time working is most frequent among the administrative and clerical, nursing and midwifery, and ancillary staff groups. Moreover, part-time working is most common amongst lower grades. For example, nearly thirty-nine per cent of nursing staff in England work part-time – a share which rises to almost sixty per cent for unqualified staff.

The advantages to the employer of part-time working include:

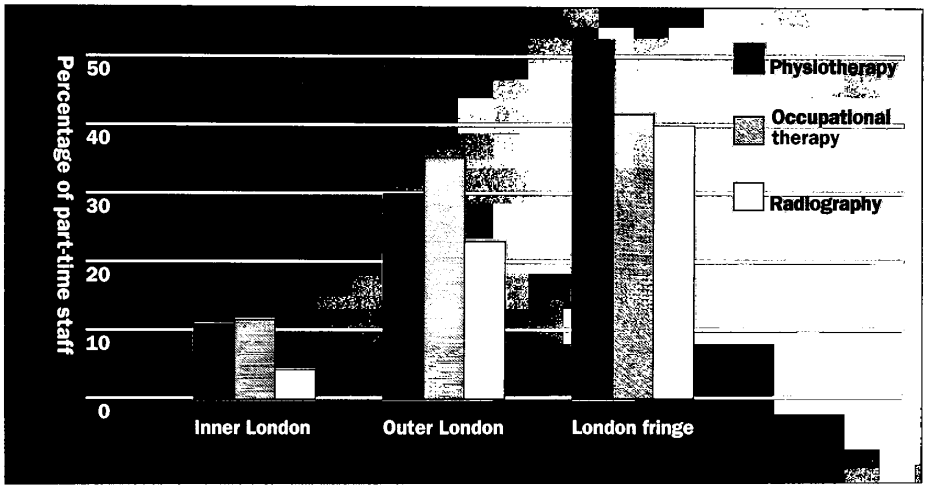
- facilitating cost-effective matching of staffing levels to workload fluctuations;
- part-timers may be cheaper per hour worked where premium rates are involved for full-timers;
- provision of part-time opportunities can alleviate recruitment difficulties;
- work rates and the quality of mature, experienced part-time staff can be greater;
- higher rates of worked to non-worked time may be achieved.

The growth of part-time employment in the NHS is largely employee-driven but has been used by managers to ameliorate recruitment problems for full-time staff. However, in London either this demand has been less or managers have resisted it. For example, less than a quarter of nurses in London work on a part-time basis. At eight per cent, Inner London has the lowest share of part-time nursing staff. This contrasts with rates of twenty per cent in Outer London and thirty-three per cent in London Fringe. Figures for London may be compared to an example from an acute/elderly unit outside Birmingham where over three-quarters of nursing and midwifery staff were employed part-time in 1988.

Nationally, one in three PAMs staff works part-time (Buchan and Pike, 1989). In Inner London the proportion of part-time staff is considerably lower. For example, only one in ten qualified physiotherapists and OTs in Inner London work part-time, compared with

Figure 4.9

PAMs: part-time staff, 1990



Source: IMS/JNPMI

national figures of thirty-seven per cent and thirty per cent respectively. In contrast part-time employment in Outer and Fringe London districts are around the national average.

Among other factors, the low proportion of part-timers working in Inner London reflects the young age profile, grade mix and the effects of high travel and other costs in the capital. It appears that there is considerable scope for the extension of part-time employment within the NHS in London where appropriate conditions of travel to work, age profiles of staff and potential recruits, and management attitudes prevail. The lower level of part-timers also reflects differences in grade mix which are discussed below.

Contracting out

Another form of flexibility in staffing services is the use of contracting out, a distancing strategy which enables the organisation to focus resources on its core activities – direct patient treatment or care. Other reasons for contracting out include:

- to reduce total costs;
- to reduce total headcount and wage bill;
- if the external contractor can provide a better-quality service.

The potential disadvantages are equally clear – for example, if the cost of the contract exceeds direct employment costs, if the quality of the service received is unacceptable, or if industrial relations difficulties are created.

In the NHS, contracting out has primarily been used for ancillary services – catering, domestic and laundry services – the majority of contracts being won by in-house bids. In the future there is likely to be increased contracting out of activities in other areas, for example payroll administration and the provision of computing services.

It is not possible to accurately quantify the extent to which

Box 4.1

WHY SKILL MIX IS A KEY ISSUE

- **Skills shortages;**
- **devolved responsibility for planning staffing and defining contracts;**
- **the search to optimise the efficiency and effectiveness with which a given volume of service is delivered;**
- **the continuing requirements to achieve good value for money;**
- **technological, legislative and philosophy of care developments;**
- **the development of competency-based training with the National Council of Vocational Qualifications (NCVQ);**
- **future planning – if future aims are at all different from now, then it is important to examine whether current skills will be appropriate in the future;**
- **helping to define targets of potential recruits, qualifications or occupations for recruitment, and selection criteria.**

(After Bevan *et al.*, 1991)

contracting out has been used in London's health care sector. An indication is provided by the reduction in ancillary staff in the four Thames regions and in the London SHAs, from 57,000 (wte) in 1981 to less than 29,000 in 1989, a fall of forty-eight per cent.

Skill mix and health care assistants

Skill mix (Box 4.1) is now recognised as one of the key issues facing the health care sector as it moves into the 1990s.

However, skill mix review is still in its infancy in the NHS and dissemination of information on completed and on-going studies is slow.

The change receiving most attention at the moment concerns the provision and training of generic support workers – health care assistants – to the professions. The initiative, as well as encouraging recruitment from the increasingly "mature" sections of the population, is intended to provide a set of support workers who possess flexibility as a key characteristic. This is to be achieved through core elements of training programmes which are of relevance across different professions within health care, with "add-on" training elements allowing flexible deployment of use to specific areas of the service and providing the individual support workers with wider job opportunities.

Nurses have always been supported by nursing auxiliaries, nursing assistants, ward clerks and housekeeping staff. Most health authorities in London are now looking at the nature of the support needed and the new roles to be undertaken.

Moreover, it is not clear where the pool of labour for this group of low-cost support staff is – the largest drop in school-leaver numbers will be in the least-qualified groups and, as we saw earlier, a large share of those currently in unqualified nursing posts will be retiring during the next ten years.

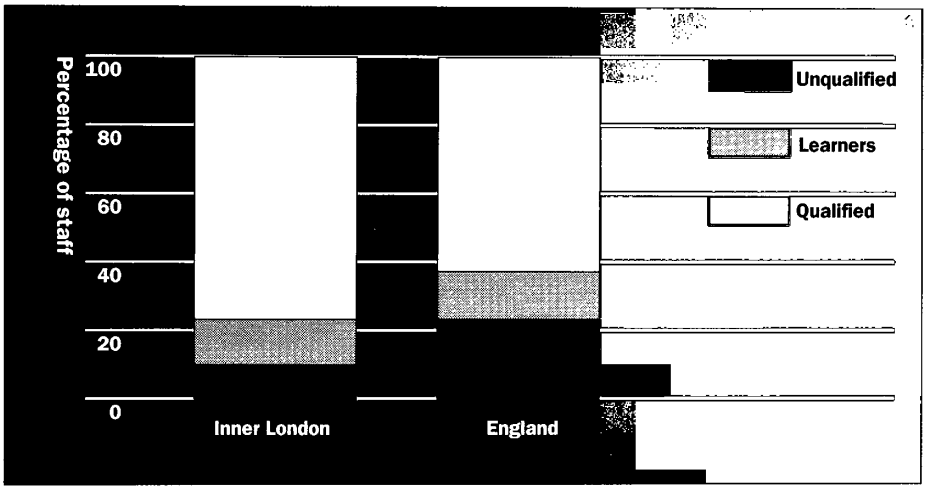
Uncertainty over the future role of nursing auxiliaries and other support workers relates to the acceptance of Project 2000, the new pre-registration preparation programme for first-level registered nurses. In particular the new programme requires students to be supernumerary to staffing establishments during their training. It is estimated that this will reduce student nurses' service contribution from around eighty per cent currently to an average of twenty per cent. Service managers will therefore have to decide how best to replace that service contribution.

The Project 2000 proposals envisaged that seventy per cent of care would be provided by qualified nurses, twenty-eight per cent by unqualified helpers and two per cent by students. A change of this magnitude will require a substantial workforce re-profiling in Inner London, where historically the ratio of qualified to unqualified staff – a crude proxy for skill mix – has been highest.

Training for the second level of the register – enrolled nurse training – has almost ceased. In London enrolled nurses form an important and hitherto more stable part of the qualified nursing labour market. From an employment perspective, they exhibit important retention and return characteristics. One of the key recruitment and

Figure 4.10

Grade mix of nursing and midwifery staff: Inner London and England



Source: IMS/DoH

retention questions to be tackled for the future is what will be done to replace this sizeable segment of the nursing workforce. The effects of the drop in enrolled nurse numbers will increasingly be felt as fewer emerge from training and the numbers in employment decline. The intake to training of pupil nurses has fallen by over seventy per cent since 1988, to under 250 in 1990, with no new intake in one Thames region. Career opportunities for enrolled nurses have always been comparatively limited, and there is concern that in the future their employment prospects will be more restricted. One solution is to "convert" enrolled nurses to the first level of the register, and so open up to them the career opportunities available to registered nurses. However, the number of places available on conversion courses has been shown to be inadequate to meet demand (Buchan and Seccombe, 1991a).

Other skill mix issues which could affect future acute service staffing requirements and costs in London include:

- roles of midwives and doctors in hospital maternity care;
- development of the specialist nurse practitioner role – dealing with certain types of case without recourse to a doctor in accident and emergency departments;
- the role of ODAs in undertaking some of the functions previously performed by theatre nurses who are both comparatively high-cost and in short supply.

Skill mix is also a key issue in the professions allied to medicine. Again, Inner London has a higher ratio of helpers to qualified staff. For example, in physiotherapy, Inner London has a ratio of 10.9 qualified staff to one helper.

Figure 4.11

PAMs: related grades as a proportion of staff-in-post, 1990

	Related grades %				
	Physio-therapy	**Occupational therapy**	**Diagnostic radiography**	**Speech therapy**	**Chiropody**
Inner London	8.5	29.2	-	4.2	-
Outer London	12.7	45.7	4.5	5.0	33.0
London Fringe	12.7	58.0	5.4	5.8	11.1
All London	12.1	48.4	3.9	5.2	25.8
England	17.3	47.4	7.0	n/a	n/a

Source: IMS/JNPMI

Grade drift

The limited use of PAMs helpers in Inner London reflects in part the problem of recruiting and retaining staff on low salaries and in occupations with poorly developed career structures for untrained staff. These difficulties are compounded by the lack of formal helper training and by the shortages of qualified staff available to supervise helpers. In some cases, helpers are primarily being used as a response to shortages of qualified staff rather than as the result of positive management action to achieve an appropriate skill mix. This can lead to a form of grade drift – allowing newly qualified staff to by-pass, or move quickly through, the basic grade irrespective of experience or capability. For example, problems with the recruitment and retention of qualified pharmacists have been tackled in some districts by increasing the role and responsibility of pharmacy technicians and pharmacy assistants, and reducing the establishment of basic-grade qualified pharmacists.

Grade drift is also a feature among the PAMs, particularly where there are recruitment and retention difficulties in the basic grades but also where there have been district mergers and where there is a strong presence of teaching hospitals with regional and supra-regional specialities and a higher proportion of senior grade posts.

Intakes to training

Major changes in the organisation of training for the health care sector will affect the future numbers available for employment in London. Some of these changes have been touched on earlier. They include:

- changes in the way training is organised for some important staff groups, for example Project 2000 changes in nursing, moving training into higher education, the move to degree-level training in some of the PAMs. These changes are likely to affect both the total numbers in training and drop-out rates during training;
- the introduction of competency-based training via the NCVQ;
- the provision of refresher training as a way of facilitating return to work;

- the provision of conversion courses for enrolled nurses;
- the provision of part-time training especially geared towards mature entrants with children.

London's hospitals, particularly its teaching hospitals, have traditionally trained more nurses than they required for their own needs and have relied on student labour for a comparatively higher share of their service input. In 1988, for example, learners accounted for eighteen per cent of nursing and midwifery staff in the Thames regions, compared with fifteen per cent in the rest of England. Inner London health authorities are training for a markedly less "local" labour market than Outer London. Only twelve per cent of learners in Inner London are recruited locally; over half are from outside London and the Thames regions (NHS, 1988).

However, the size of the learner population in the Thames regions has reduced since the mid-1980s, falling by eleven per cent from 21,670 in 1986 to 19,230 (wte) in 1990 (DoH, 1991). This compares with a decline of just under eight per cent in the rest of England. Despite this, the Thames regions still account for thirty-two per cent of learners. Although separate figures on learners are not available for London, it is estimated that a little over three-quarters of this learner population are in London districts (NHS, 1988).

New intakes to pre-registration nurse training in the Thames regions have actually increased in the last two years, growing by eight per cent from 6367 in 1988 to 6883 in 1990. However, this figure includes those taking further pre-registration training – enrolled nurse conversion courses – and may not reflect any underlying change.

Intakes to training in other professional groups have also reduced. For example, evidence from North West Thames shows that student intakes to radiography training declined during the mid-1980s, but began to recover in 1988 and 1989. This parallels the national trend and reflects the introduction of more flexible entry requirements. In particular, the number and share of both male students and of mature (over twenty-one) students has risen. Nevertheless, intakes remain well below the number of available funded places in some schools.

With moves towards regional self-sufficiency in training, the

Figure 4.12

Entrants to training by course of study and region, 1988–90

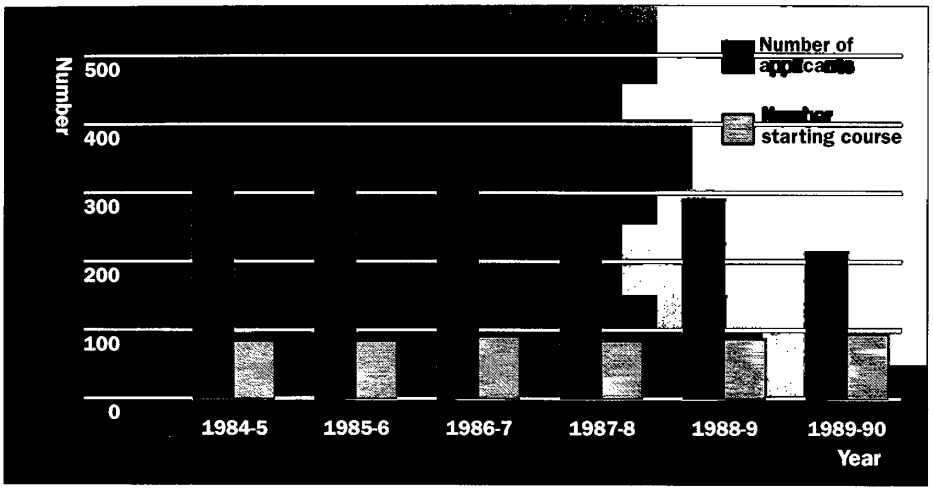
Region	Registered Nurse Training			Enrolled Nurse Training		
	1988	1989	1990	1988	1989	1990
NW Thames	1340	1453	1375	257	170	62
NE Thames	1808	2246	2396	260	169	120
SE Thames	1379	1594	1745	167	120	41
SW Thames	1023	1076	1144	133	36	0
Thames total	5550	6369	6660	817	495	223
change %	-	+14.8	+4.6	-	-39.4	-54.9
England total	17,642	19,183	19,688	2625	1694	591
change %	-	+8.7	+2.6	-	-35.5	-65.1

Source: DoH

Note: All figures include those undertaking further pre-registration training; figures for 1990 include P2000 students

Figure 4.13

Trends in student numbers at the London School of Occupational Therapy, 1984–89



Source: IMS/Sturdy and Vinten 1990

problem for the London-based schools is that a high proportion of students come from outside the London area and a high proportion will look for their first appointment, or first career move, outside the capital. For example, less than a third of those graduating from the West London Institute School of Physiotherapy in 1987 were subsequently employed in the London area (Jepson and Burnard, 1990).

The Single European Market

In the face of continuing staff shortages the advent of the Single European Market appears to open up the prospect of recruitment in other EC member states.

In reality, there has been comparatively little exchange of nurses between the UK and mainland Europe, despite the existence of EC directives permitting the movement of nurses (since 1979) and midwives (since 1983). As such, the much lauded 1992 Single European Market has little relevance to the free movement of first-level qualified nurses and midwives. They already possess this freedom. Nevertheless, limited survey evidence suggests that overseas nationals working in the NHS are concentrated in London and the South East (Salt, 1990). In 1984–85 there were only 223 admissions to the UK register from the EC. Although numbers have grown rapidly since then (reaching 992 in 1989–90), they are insignificant, applicants from Eire accounting for just under two-thirds of the total.

Non-EC additions to the UK register, mainly from Australia and New Zealand, have remained comparatively constant at 2185 in 1989–90, bringing the total inflow to the UK to 3175 (UKCC, 1991). This represented ten per cent of admissions to the register – that is, one in ten "new" UK registered nurses had previously been registered abroad. Without a clearer picture of how many remain in the UK, and for how long, the cost-effectiveness of this source of recruitment is difficult to assess (Buchan, 1991).

Relatively little direct recruitment has taken place in mainland

Europe. Individual examples include Basildon and Thurrock Health Authority, which recruited twenty-three Spanish nurses, including seven theatre nurses, in 1989, following an approach from Spain to the Department of Health.

The drop in school-leaver numbers across Europe, combined with widespread nursing shortages in other European countries, suggests that recruitment from abroad is unlikely to play a significant part in ameliorating staffing problems in London. Few health authorities have sufficiently detailed information on skill surplus and demographic patterns in Europe on which to base such recruitment initiatives.

Issues for the future

This chapter has considered a broad range of issues affecting the supply of labour to the health care sector in London. Some of the key points emerging from this analysis are as follows.

- The age profile of qualified and professional health care staff in London tends to be younger than in England as a whole. Survey data shows that over half the qualified nurses in London are aged under thirty-five.
- Vacancy rates in London are higher than in the rest of the country; thirteen per cent of qualified nursing posts and eleven per cent of PAM posts in London were vacant at the start of the 1990s.
- Rates of job change are comparatively higher; in 1990, thirty-six per cent of qualified nurses and just over thirty per cent of qualified staff in the PAMs group left posts in London.
- A comparatively small share of staff work part-time in London, particularly in Inner London; less than a quarter of nurses in London work part-time.
- The number of agency and bank nurses employed in London grew rapidly in the 1980s.
- London has a higher ratio of qualified to unqualified staff; among nurses the ratio may be as high as 9:1 in parts of Inner London.
- The size of the learner population in the Thames regions has reduced since the mid-1980s, falling by eleven per cent from 21,670 in 1986 to 19,230 in 1989.
- The intake of pupil nurses has reduced to less than 250.
- A high proportion of entrants to training come from outside the London area and will look for their first appointment, or first career move, outside the capital.

As new young intake, particularly to nursing and the PAMs, falls, and emphasis moves to retention, re-entry and mature entry, the age profile of the workforce is likely to grow older. This will in turn have significant implications for working patterns, the demand for part-time

work, career opportunities and post-basic training for "mature" recruits and re-entrants, and flexible employment opportunities for returners.

With emphasis moving to measures to improve retention and stimulate return from the qualified staff not currently in the NHS, there is a need to ensure that these measures are appropriately targeted and tailored. This means recognising for example that most nurses and therapists are female, and that many will continue to have non-employment responsibilities, whilst also accepting that domestic commitments do not preclude career orientation or a desire for professional advancement. In the next chapter we will turn to these issues.

CHAPTER 5

Pay and non-pay initiatives: the key employment issues

This chapter considers issues of employment in health care in London, placing the statistical indicators examined previously in a broader policy framework. The initial focus is on recruitment and retention of health care staff in London at a time of economic recession. Specific aspects of recruitment and retention in London are then considered. These include pay and labour costs, accommodation and transport, and non-pay initiatives.

Recruitment, retention and recession

This review was conducted at a time of general economic recession and rising unemployment. London and the South East, traditionally regarded as the most prosperous areas in the country, have experienced an increase in unemployment at a pace which has exceeded the national average.

To an extent, health care employers located in the public service sector are protected from some of the vagaries of the business cycle (in the short term at least), and health care employers in London have in fact benefited from the labour market impact of recession. Recruitment to non-health specific employment in ancillary, administrative, secretarial and clerical posts has eased markedly, as the private sector has shed labour, and private sector vacancies have reduced. North West Thames RHA (1991) noted that:

> *West London DHAs have recently experienced an overwhelming number of applications for vacant posts ... due to redundancies currently resulting from staff cutbacks at Heathrow.*

The broader economic impact of high interest rates and mortgage costs, and recessionary effects on the employment of spouses or partners has also affected labour market behaviour in health-specific

Figure 5.1

Unemployment rates, 1987–91

Unemployment (% of workforce)

	1987	1988	1989	1990	Jan. 1991	Apr. 1991	Aug.* 1991
Greater London	8.5	6.8	5.1	5.0	6.1	7.4	8.6
Great Britain	10.4	8.2	6.1	5.6	6.7	7.6	8.4
London as a % of GB	82	83	84	89	91	97	102

Source: Employment Gazette, October 1991. Department of Employment

*Provisional

occupations. As we saw in the previous chapter, turnover among nursing staff reduced markedly between 1989 and 1990; discussions with personnel managers in trusts and units in 1991 indicate that this trend has continued and that an important factor in this changed behaviour has been the impact of recession.

The recession and its effects are outside the control of health care employers. They may be able to gain a competitive advantage by exploiting its labour market repercussions but this is a windfall gain, and it should not be allowed to divert attention from the broader long-term demographic and labour market indicators which were reviewed in earlier chapters.

The indicators examined in the previous chapter revealed that health care employment in London is generally characterised as exhibiting higher turnover, higher vacancies, higher grade mix and higher use of agency staff than elsewhere in the country. The unplanned, immediate and short-term effect of recession has been to reduce the impact of some of these indicators. Discussions with personnel staff in trusts and units suggest that cost containment pressures will have a similar planned and longer-term effect. However, at the time of writing, London remains the labour market where health care employers face the greatest challenge in recruiting and retaining staff.

Interviews with personnel staff in London hospitals revealed that many have experienced a general downturn in recruitment and retention difficulties. These were related to three main factors, one external (the impact of recession) and two internal (the effect of new pay/grading initiatives, and the effect of non-pay recruitment and retention incentives). Most discussants acknowledged that the "window of opportunity" provided by economic recession was only temporary, and some expressed concern that the easing of recruitment difficulties was drawing managerial attention away from establishing more permanent and positive changes in employment practice.

Whilst recruitment and retention difficulties were generally agreed to have eased, specific grades, occupations, and specialities continued to prove problematical. The underlying reasons are two-fold:

- national shortage of specific skills; for example, there are insufficient specialist theatre nurses to meet demand;
- in non-health specific occupations, national shortages are compounded by uncompetitive NHS pay rates; for example, the NHS cannot compete, on pay terms, in recruiting specialist computer staff.

Recruitment and retention is often characterised solely in the context of pay levels and pay determination. In reality the reasons why individuals decide to train for, join or leave a particular occupation or employer are much more complex.

Pay levels in London have traditionally been higher than elsewhere in the country. Across the whole economy, the London differential was plus thirty per cent for men working full-time in 1990,

Figure 5.2

Average gross weekly earnings (full-time workers), 1990

	Greater London £	(London as a % of GB)
Male:		
All occupations	383.1	(130)
Professional and related in education, welfare and health	374.7	(110)
Female:		
All occupations	258.9	(128)
Professional and related in education, welfare and health	283.3	(110)

Source: New Earnings Survey, 1990, part E

and plus twenty-eight per cent for women working full-time. Over the last twenty years, this differential has increased, whilst differentials between other regions of the country have narrowed.

In contrast to the overall differential, that for professionals in education, welfare and health (mainly teachers, social workers and nurses) is much less pronounced, at plus ten per cent. This narrower differential is partly a function of continued national pay determination in the public sector.

Pay determination in the NHS has always been occupation-specific and centralised at national level. In recent years, the Whitley Council system of determination, with representatives of staff side organisations negotiating with management side, has operated in parallel with the review body system. The review bodies cover the major NHS specific professions (doctors and dentists, nurses, midwives and health visitors and the professions allied to medicine), whilst the non-specialist staff continue to have their pay levels determined within the Whitley machinery.

Whilst many NHS local managers may wish further freedom in determining appropriate levels of pay for their staff, it has to be recognised that the success of greater flexibility is predicated on two assumptions: that there will be sufficient finance generated through contracts or from central sources to fund this flexibility, and that greater flexibility can have a positive impact as a cost-effective method of improving recruitment, retention and commitment of staff.

London pay enhancements

In common with most other employers, the NHS offers salary enhancements to staff who work in London, partly to compensate for the higher cost of living in the capital, and partly as a recruitment and retention incentive.

There are three main forms of pay enhancement:

- London "weighting" – a flat-rate payment to all staff in each NHS occupation (but varying between occupations). Paid at different levels in "Inner", "Outer" and "Fringe" London.

- London "supplement" – a percentage-rate payment to all staff in some occupations, e.g. nursing and midwifery. Paid at different levels in "Inner", "Outer" and "Fringe" London.
- "Flexible pay" supplements – paid on a non-recurring basis to some individual employees, in some posts, in some occupations.

This complex payment system is a recent development; previously only a flat-rate London weighting was paid. Increasing complexity has arisen primarily as a result of attempts to improve recruitment and retention in London by so-called "targeting" of enhancements.

London "weighting"

London weighting is the traditional form of payment in both public and private sectors as compensation for higher living costs in London. Paid as a flat rate to all staff within a defined geographical region, it is simple to administer, but a non-specific and rather blunt instrument for tackling recruitment and retention problems.

NHS London weighting levels are generally competitive within the public sector, but lag behind payment levels in private sector organisations.

London "supplement"

An additional London supplement has been introduced in recent years for a number of NHS occupations. This is a payment in addition to London weighting, and is paid as a proportion of salary. All NHS nurses and midwives first received this payment in 1988–89; those working in Inner London currently receive five per cent of salary up to a maximum of £680 per annum.

The combination of a flat-rate weighting payment and a propor-

Figure 5.3

Inner London weighting, 1990 (staff)

Employer	(£)	London weighting
Barclays	3400	
Abbey National	3000	
Commercial Union	2850	
BP	2900	
BBC	2000	
Boots	1736	(+392 discretionary)
British Gas	2500	
Fire service	2070	
Local authority (admin. and prof.)	1722	
NHS – admin. and clerical	1702	(+ discretionary)
– nurses and midwives (qualified)	1550	(+ 5 per cent of salary)
– hospital doctors	1200	
Police	2181	
Teachers	1500	(+750 discretionary)
FE lecturers	1500	
Civil service (non-industrial)	1750	(+ up to £1000 supplement)

Source: London and South-East Allowances, (Incomes Data Services,1990)

Figure 5.4

London weighting and London pay supplement for nurses and midwives, April 1991–92*

Grade	Inner London			Outer London		
	Basic	Additions	% on basic	Basic	Additions	% on basic
Grade A mid-point	7345	1792	24	7345	1572	21
Grade E mid-point	12520	2326	19	12520	1931	15
Grade G mid-point	16525	2380	14	16525	1885	11

Source: Review Body (1991)

* Assumes no "staging" of pay increase

tionate supplemental allowance represents a significant salary enhancement for lower-paid staff, in percentage terms. For a nursing auxiliary on the mid-point of grade A, working in Inner London, the increase is twenty-four per cent on basic pay; for a grade G ward sister in Outer London the combined increase is eleven per cent on basic salary.

The introduction of the London supplement for nurses and midwives was recommended by the Review Body in 1988 and was the result of evidence received which demonstrated recruitment and retention problems in the capital. Similar supplements are available for the professions allied to medicine.

Flexible pay supplements

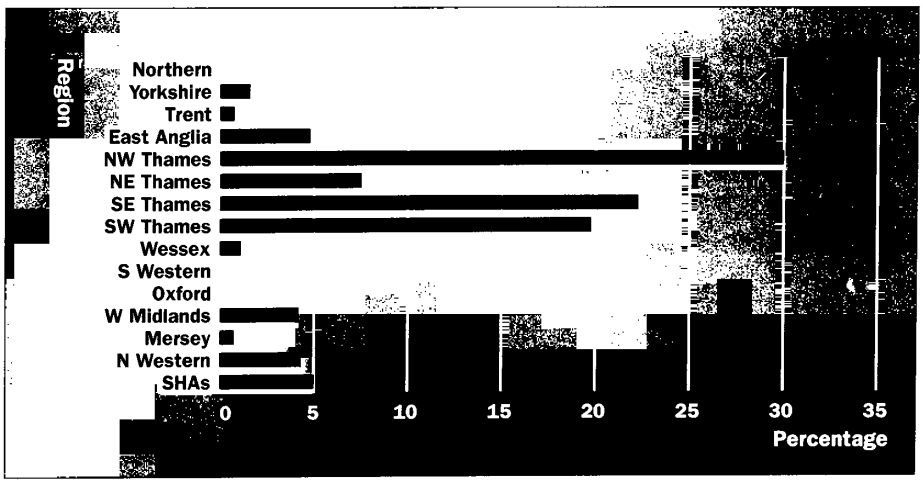
A third, optional, element in the pay packet is the flexible pay supplement, which is awarded on a discretionary basis for "hard to fill" posts. Cash-limited flexible pay schemes operate throughout England for nursing and midwifery staff and for administrative and clerical staff. Individual employing units make "bids" to the Department of Health for additional funding to pay supplements for posts deemed to be problematical in terms of recruitment and retention.

London health authorities were excluded from the first round of the nurses' flexible pay scheme, but were allowed to bid during the second year of the scheme, in 1990–91.

Nearly eighty-five per cent of the money allocated went to the four Thames regions, or to the SHAs. However, care should be taken

Figure 5.5

Nurses' and midwives' regional allocation of flexible pay supplements, 1990–91 (total paybill £4.8 million)



Source: IMS/DoH

in using the pattern of allocations as some indicator of geographical variations in skill shortages in nursing. For example, it is extremely unlikely that North West Thames and North East Thames vary in labour market conditions to the extent that would be indicated by the difference in the level of their bids. The pattern of allocation is more relevant as an indicator of shortage by speciality – theatre, ICU, paediatrics, mental illness and mental handicap were all specialties which benefited.

Some health authorities decided not to apply for the scheme, regarding it as potentially divisive. Some employing authorities were particularly enthusiastic in applying for monies; others participated, but with less enthusiasm – partly because the application procedure is perceived to be time-consuming, bureaucratic and centralised, and partly because some managers have doubts about the recruitment and retention effects, and its impact on the morale of staff not receiving the supplement. South West Thames RHA (1991) in a recent report noted:

> *Nursing pay supplements had been widely used. In contrast to the muted response regarding A & C groups, there were some criticisms of nursing pay supplements because of the division they had caused and their demoralising effect among those not receiving them.*

At the time of writing, an objective evaluation of the labour market effects of the scheme is awaited.

The move from an organisational culture based on centralised pay determination to one based more on individual reward can be related to political imperative and resource limitations, as well as reflecting managerial desire to motivate and to improve recruitment and retention. It remains to be seen whether these diverse requirements can be reconciled in a manner which has an overall net beneficial effect on recruitment and retention. In London, as elsewhere, much will depend on how much funding is available for the paybill, how that funding is allocated and how that allocation measures up to pay levels and pay changes elsewhere in the labour market.

The London labour market is likely to be the major testbed for assessing the impact of greater NHS pay flexibility. The fact that so many units and trusts share a large labour market is likely to exert pressure on pay levels, particularly for staff with health care-specific specialist skills.

If the free market operates and trusts and units do not collaborate to set agreed levels for pay, this issue could be exploited by trade unions and professional organisations, who could "pick off" individual employing units with high pay awards, leading to an upward pay spiral. It is more likely that trusts and units will collaborate, either formally or informally and either overtly or covertly, to establish commonly accepted parameters for pay awards, so that unfettered pay competition, with its commensurate dangers (from a managerial perspective), is prevented. There is already evidence that informal collaborative arrangements are being developed in parts of London, with NHS units exchanging information and expertise on pay determination. A continued role for regions (or for a London-wide body) could be pay

research and the monitoring of pay awards, both in the NHS and elsewhere.

In the longer term, the net effect of such strategies on recruitment and retention in London acute services is unclear. Whilst competitive levels of pay will be important in recruiting and retaining staff (particularly those with non-health-specific skills), it will be equally important to ensure that other factors, such as career development and participation in decision-making, are maintained and enhanced.

Labour costs

Health care is labour-intensive. It is estimated that approximately three-quarters of the running costs of hospitals relates to the wage bill. Salaries and labour costs are therefore the main focus of any managerial attempt to contain costs – by employing relatively "cheaper" staff, or by employing staff more "cheaply", through improved utilisation and deployment.

Labour costs of health care employers in London have always tended to be higher than the national average, because of London pay supplements, because of a higher qualified:unqualified staff ratio, and because of grade drift. The NHS resource allocation mechanism (RAWP) has recognised these higher costs in its regional allocation formula, but recent commentators (Akehurst *et al.*, 1991) have suggested that the London addition is insufficient to compensate for higher labour costs in London.

Accurate estimates of unit labour costs in the NHS are currently being developed as a matter of priority in order to assist in costing of services and to inform pay determination. Current indicators, based on incomplete data, suggest that unit labour costs, and cost per case, are higher in London than the national average. However, just how much higher cannot be measured precisely.

Skill mix

Achieving the most cost-efficient "mix" of staff, and ensuring that they are deployed effectively, is a major requirement for any employer. For an organisation as complex as the NHS, with a multi-occupation, multiprofession workforce, operating twenty-four hours a day, every day of the year, staff mix and deployment is a priority which has to be balanced carefully against level and quality of service provided.

The examination of the profile of the NHS workforce in London

Table 5.6

Expected increases in cost per case (%) due to higher labour cost in London (net of London weighting)

Source: Akehurst *et al.*, 1991

	1980	1987
Rest of Thames over rest of England	0.4 to 0.7	1.6 to 2.6
London over rest of Thames	1.6 to 4.7	1.2 to 4.0
Outer London over rest of Thames	n/a	0.6 to 2.8
Inner London over Outer London	n/a	1.2 to 3.7

revealed that it had a higher proportion of qualified staff than elsewhere in the country, due, in part at least, to the high proportion of teaching hospital and research commitments in the capital (and also because of "grade drift", as London health care employers paid higher grades to attract staff).

This "grade mix" is often used as a proxy measure for skill mix, which is more complicated to define and measure. Grade mix also allows a rough "costing" of various workforce profiles, using the salary costs of different grades as a cost indicator of their required skills.

Units and trusts are currently examining grade mix and skill mix, with a view to finding ways of achieving savings on labour costs.

Major areas under consideration include:

- substituting health care assistants and other support workers for qualified nurses;
- increasing the use of unqualified "helper" grades in some of the professions allied to medicine;
- increasing the use of technical grades in pharmacy;
- developing nurse practitioners to undertake work currently within the purview of medical staff. (A stimulus to this will be the reduction in junior doctors' hours.)

In most instances, the primary objective in these reviews is cost containment. It should be stressed that, at the time of writing, there is little evidence that significant re-profiling has taken place in London. For the most part, such changes are still at the planning stage. Whilst the implementation of the NHS Act has given a specific stimulus to such reviews, many employing units in London were already assessing their staffing requirements and costs. Recent examples of London hospitals announcing staff cuts owe less to post-April 1991 trust status and more to long-term staffing trends than some media coverage would suggest.

Discussions with personnel staff at units in London reveal that many trusts and directly managed units are reviewing grade mix with a view to reducing the proportion of qualified (higher-cost) staff working in clinical areas, by increasing employment of health care assistants and other support staff. One recent NHS commentator (Rogers, 1991) suggested that the qualified:unqualified mix in nursing could alter from 70:30 to 45:55 over the decade. Whilst the cost-saving potential of such an alteration in grade mix can be readily demonstrated (see Figure 5.7) it is less easy to assess the implications of such a change

Figure 5.7

Pay differentials: nursing staff, 1991

Note: Assumes that 1991 Review Body Award was not "staged"

	Inner London	**Non-London**
Staff nurse (mid-point grade E)	£14,846	£12,520
Auxiliary (mid-point grade A)	£9137	£7345
Auxiliary as a % of staff nurse	61	59

on the level, quality and continuity of care delivered. It should also be noted that the "flat-rate" effect of London weighting tends to narrow pay differentials between qualified and unqualified grades, so the net saving of altering grade mix may be less pronounced in London than elsewhere in the country.

The other major focus of management attention is on achieving more efficient deployment of staff, by examining current shift patterns and shift overlaps, and by improving the methodologies used in relating staffing levels to workload.

Non-pay incentives

Pay, including London-related enhancements, is one major element in the recruitment and retention strategy of any London-based employer. Non-pay-related incentives are also important, particularly for the health care sector, which often finds it difficult to compete solely on pay terms.

One incentive which should not be underestimated is the provision of training opportunities, at pre-qualification and post-basic level. The concentration of training provision in London has made the capital a natural choice for career-oriented health care professionals (particularly those in the earlier phases of their career). A number of management respondents stated the importance of post-basic specialist training as a retention measure to retain newly qualified professional staff in the capital.

Four other broad areas of management initiative on non-pay can be identified. These relate to accommodation, transport, working hours, and child care. Whilst it is possible to outline the various forms this action can take, it is difficult to establish a detailed overview of the extent of current provision of these incentives by health care employers in London, as many are left to the initiative of local management.

Accommodation

The payment of London-based enhancements to national rates of pay has been, partly at least, a recognition of the high cost of living in the capital. It should be noted that the differential between London and elsewhere has narrowed in the last two years with the impact of the recession and high interest rates, but London remains a high-cost area in which to purchase property.

High housing costs in London have a number of labour market effects. Home ownership amongst NHS employees is at a lower level in London than elsewhere in the country, with more staff (particularly younger, single employees) renting accommodation.

House price differentials also act as a disincentive in staff mobility to and from the capital. In a large-scale survey of qualified nurses, the South East was generally perceived as the least attractive area to work in due to housing costs, inner city problems and disruption to partner and family (Buchan *et al.*, 1989).

Accommodation costs and availability are important factors in

Figure 5.8

House price differentials, first quarter, 1991

Source: Nationwide Anglia Building Society House Price Index, Spring 1991

	UK average	Greater London	Outer Met. area	Outer South East
Detached house	100	149	137	104
Semi-detached house	100	153	133	104
Terraced house	100	157	129	105
Other	100	124	112	94
All	100	128	136	112

Figure 5.9

Qualified nurses: type of accommodation, 1990

Source: IMS/RCN

*Parental home, housing association etc.

	Private	Private rented	NHS	Public rented	Other*
Inner London	57	20	7	5	11
Outer London	76	9	8	3	5
London Fringe	83	4	7	5	2
UK	82	6	4	3	6

shaping the profile and dynamics of the London health care workforce. Inner London has a higher proportion of young, single full-time health care professionals than the rest of the country. Many were attracted to London by the training and career opportunities available in the teaching hospitals. They are willing to live in rented accommodation or share accommodation in order to have the career benefits of post-basic training and experience in London. They tend to exhibit high job mobility between jobs in London in their first few post-qualification months or years before moving out of the capital. As other regions increased training opportunities and as house price differentials between the South East and the rest of the country widened in the 1980s, London teaching hospitals experienced greater difficulty sustaining the inflow of non-London recruits to basic training.

Recently a number of local initiatives have been undertaken to improve the volume and condition of accommodation available to NHS employees in London. These have included joint initiatives with housing associations to construct and manage new accommodation (for example, Barnet Heath Authority and the Bradford and Northern Housing Association) and to develop shared equity housing (North West Hertfordshire Health Authority and Metropolitan Housing Trust).

Transport

A related issue facing all London-based employers is the transport infrastructure and transport costs. Employers based near mainline railway stations (and this includes several teaching hospitals and three of the regional health authorities' head offices) may be in a position to tap into the commuting market, but travel costs are such that it is likely

to be the better-paid (often full-time) staff who commute. More generally, the cost of travel and transport availability for the many health service staff who work unsocial hours and shiftwork are factors of significance in determining which "pools" of labour a health care employer can recruit from. Some employers provide assisted transport (for example, a hospital bus) to broaden their potential labour market, but most staff are dependent on public transport or their own transport provision. The catchment area for lower-paid ancillary and support staff, who often rely on public transport, can often be comparatively small, and is delineated by bus or tube routes.

More generally, the transport issue can be particularly problematical for staff who wish to work part-time. If they choose to work five half days, they have to meet the same travel costs as a full-time employee; if they choose to work two or three days a week they will lose the benefits of discounted weekly or monthly travel passes.

Working hours

One significant feature of health care employment is the high proportion of staff who work shifts, outside the parameters of the so-called "normal" working week of nine am to five pm, Monday to Friday. The requirement to provide a twenty-four-hour service creates problems for health care employers, in terms of ensuring that sufficient staff are available during "unsocial" hours. However, it also provides opportunities to establish novel, non-traditional, working patterns if these are perceived as beneficial to recruitment and retention.

The NHS has always relied on a high proportion of part-time employees to staff the service. Part-timers have traditionally been concentrated in the unqualified occupations and in the basic clinical grades in the female-dominated professions of nursing and the professions allied to medicine.

Lower proportions of part-timers are employed in Inner London, partly because the "supply" of part-timers is smaller due to demographic patterns and because of travel costs, and partly because the demand for part-timers is lower, due to a preference (particularly evident in some of the teaching hospitals) to employ full-time staff in the professions.

Part-time employment is particularly attractive to many "mature" women with domestic responsibilities. Demographic change, with declining numbers of school leavers and reductions in outputs from training for some of the professions, means greater emphasis is being placed on mature entrants and re-entrants to employment in the health care sector and elsewhere. In this scenario of an "ageing" workforce, more of the health care workforce in London will be in the age range demanding part-time employment.

The challenge to health care employers in London, if they wish to maintain their share of the labour market (if supply-side constraints increase), or if they wish to tap further into under-utilised pools of available labour, will be to increase the part-time opportunities available to prospective employees, and to ensure that many more of

these opportunities are in career-related promoted posts with higher pay levels than is currently the case. In particular, job sharing and flexitime, provision of in-house agencies and nurse "banks" and flexible contracts, which are all features of part-time employment currently provided by some health care employers, are likely to become more widespread.

One other issue related to working practice is the extent to which the purchaser/provider system will encourage employing units to employ more staff on term contracts, linked to the winning of contracts to provide designated health care services. This may affect professional staff currently regarded as "core" permanent staff, as well as support staff who are already the subject of "contracting out".

Child-care issues

There is a large overlap between working hours issues and child-care issues. Many part-timers, job sharers and employees working flexitime do so because of child-care commitments. In a workforce with a high proportion of female staff, issues relating to the balancing of domestic and employment commitments are of particular significance to staff recruitment and retention.

Employers' involvement in child-care provision can take three forms. Firstly, they can offer working hours which facilitate child care (in the longer term, this can include offering attractive school holiday leave, maternity and paternity leave, and career break packages). Secondly, they can provide "on-site" child-care facilities. Thirdly, they can subsidise child-care costs directly, or indirectly by offering "child-care vouchers", which can be used by employees to purchase nursery school or childminder provision. It should be noted that child-care provision is, in overall terms, less relevant in Inner London, where fewer staff have dependent children, as the age profile of staff is younger.

Figure 5.10

Qualified nurses with dependent children and dependent relatives, 1990

	Dependent children	Dependent relatives
Inner London	24%	3%
Outer London	40%	11%
Fringe	47%	9%
UK	44%	15%

Source: IMS/RCN

"Managed" career breaks and designated time off for child care (other than statutory maternity leave) are comparatively recent developments, in the health care sector and elsewhere. Career breaks of an agreed time limit, with employer and employee keeping in touch, and with a "same or similar" job offer on return, are primarily a mechanism for employers to ensure that they obtain a sufficient return on training investment. As such, their provision tends to be restricted to certain designated occupations, grades or posts.

On-site crèche and child-care facilities are provided by some London hospitals, but the extent of provision in any one site is limited. North West Thames RHA reported some form of crèche/playscheme provision in nine of its thirteen districts in 1989 (NWTRHA, 1989). South West Thames RHA recently estimated that the "typical" district HA was able to offer a place in a crèche to approximately fifty children (SWTRHA, 1991).

The demand for crèche provision in the capital exceeds supply, as South West Thames RHA noted: "the majority of crèches within the region were over-subscribed with long waiting lists...". This leads

to some system of allocation being used, which may involve sliding-scale charges, or may be based on "preferred status" being given to certain designated occupations or grades.

Crèches can be an effective recruitment and retention mechanism, but are costly to run, partly because they are a taxable benefit. Some health care employers have established joint ventures with private sector employers (notably the Midland Bank) to underwrite crèche costs, and some teaching hospitals have used trustee funding to subsidise capital costs and charges. Crèches are likely to be more attractive to locally based employees, or employees with access to their own transport.

Child-care vouchers are a comparatively new initiative being considered by some London-based health care employers. They allow employers to assist in child-care costs, and to market themselves as "child-friendly" without incurring the set-up capital costs of operating an in-house crèche. They also allow employees the flexibility to choose their own form of child care, in a suitable location.

Future employment issues

The previous sections of this chapter have considered various aspects of health care employment. In the final section we assess likely future developments in employment practice, and review their possible impact on labour supply.

Pay and labour costs

Current trends in remuneration policy, in the NHS and elsewhere (Metcalfe and Thompson, 1991), point to greater individualisation of pay and conditions, with the "reward package" of individual employees comprising a greater element of performance-related, geographical-location-related and skill-shortage-related enhancement.

NHS trusts in particular are planning to reduce the relative importance of across-the-board salary increases in favour of targeting available funding at staff who perform "well" (at the time of writing, measures of performance in the clinical setting remain vague, and some trusts are looking to establish "team" performance systems), and at posts that are perceived to be difficult to fill. However, there is little evidence that any radical departures from national terms and conditions have occurred in the short term (Buchan, 1992 forthcoming).

Grade mix and deployment

In common with developments in NHS pay determination systems, it is likely that it will be in the NHS trusts that the effect of skill mix reviews and changes to deployment practices will first become apparent, but significant changes in current employment practice will not be restricted to the trusts.

In essence, managers at local level will be questioning and challenging the custom and practice in employment issues of NHS

professions much more closely than has previously been the case. Whilst the framework for this challenge has been created by the implementation of the NHS Act, NHS management will also have to face the even greater challenge of auditing quality of care when effecting these cost-containment-led changes in employment and deployment of staff.

It appears likely that changes in the profile of the health care labour force in London will match trends elsewhere. On current assumptions of future met demand, there is little likelihood of any significant growth in numbers of qualified and professional employees in the acute sector, in net whole-time equivalent terms. However, there are strong indications that the qualified:unqualified ratio will alter, as more "cheaper" support workers are employed to deliver much of the health care, under the management and supervision of health care professionals.

The pace of alteration in grade mix is likely to vary in different locations and in different health care specialisms, and may not be accompanied by the same level of media attention as occurred when some London hospitals announced significant levels of redundancies. However, the implications of grade mix alterations on employment levels and practices in the health service and on the delivery of care are likely to be far-reaching.

Non-pay initiatives

Information on the extent of provision of non-pay recruitment and retention incentives is fragmented, and it is difficult to establish a London, or national, overview. It is evident, however, that provision has increased in recent years, due to labour market pressures, and that this increase has been more apparent in the south of the country than in the north.

The recent impact of recession has reduced, in the short term, the pressures on health care employers to examine and offer such non-pay incentives, but a number of factors are likely to stimulate a further increase in provision. These factors relate to reduced labour supply and increased competition as demographic decline impacts, and recession eases, and to the ageing of the workforce increasing demand for child-care support and for flexible hours. However, implementation of the NHS Act will also increase opportunities for employers to provide a more flexible employment package (for example, cafeteria benefits in NHS trusts).

Career break schemes and maternity and paternity leave are likely to become more prominent, particularly if EEC legislation is implemented, but because of administrative and management costs, and an unfavourable tax regime, the provision of on-site crèche facilities is likely to remain comparatively limited. In future it is likely that more crèche places will be targeted at designated occupations or grades. Child-care vouchers are comparatively untested, but may be developed as an integral element in cafeteria benefits type payment systems.

CHAPTER 6

Conclusion: challenges for the future

The final chapter of the working paper tries to set the findings of the study in the context of what is happening to the NHS now and into the next century, and points to the major lessons for shaping manpower planning and labour market policy to meet these changes.

A significant, though largely negative, finding in the study was that none of the personnel functions visited was in a position to undertake the kind of detailed assessment of medium or long-term labour requirements which is necessary for effective and planned interventions in the labour market. The overwhelming concern was with the immediate issues posed by implementation of the NHS reforms.

Future met demand

Establishing a robust estimate of the future *met* demand for acute services – and hence staffing requirements – in London is outside the remit of this paper and is in any case not readily achievable given the complex interaction of factors which create met demand.

There are a number of variables which are likely to modify predicted acute service volumes. Some of the most important of these have recently been described in the South East Thames RHA report (SETRHA, 1991) *Shaping the Future: a review of acute services*. These are outlined below.

Shifting from acute to primary care

More acute work may be carried out in the primary care sector. Examples include: increased primary care minor surgery; improved coordination with social services to expedite discharge and promote recovery.

The potential for direct transfer of a substantial volume of work to primary care in London is uncertain. The provision and quality of primary health services in London has long been recognised as patchy. Despite recent trends towards the agglomeration of practices, London has seventy per cent more single-handed GPs, and forty per cent fewer primary care support staff, than average. As a result many more people end up being treated in hospital.

Changes in provider efficiency

Increased activity combined with a reduction in the number of available acute beds has been a feature of the last ten years. This trend is expected to continue, albeit at a slower rate. In particular, it is

anticipated that further growth in day case surgery will contribute to greater service capacity.

The South East Thames report also points to improvements in provider efficiency which would arise from the separation of acute and elective facilities – for example, emergency admissions would no longer result in last-minute cancellation of planned operations.

Changes in therapeutic and investigative technology

Developments in keyhole surgery and elsewhere will impact on the amount of treatment that any one hospital can undertake. The nature and timing of such changes is, however, unpredictable.

Demographic change

Since 1971 Greater London's population has declined by more than 870 thousand (twelve per cent). Over the next twenty years this decline is expected to be arrested, with a net increase of around two per cent by the year 2011.

The single most obvious population change in the future which will affect the demand for health care provision is the growth in numbers of elderly people. Elderly people not only have special demands – for elderly care hospital and community services per se – they also make up the majority of acute hospital in-patients and the majority of patients on many health care professions' case-lists. The latest projections show that by 2011 the total number of residents over sixty-five will have risen by more than 18,000. An increase in the number of elderly people affects both the demand for staff in the acute sector, and the supply – by increasing the numbers of staff (or potential staff) involved in home care.

Demography will affect London in other ways too – under the NHS reforms, government funds will be allocated to purchasing authorities according to a capitation formula which takes population weighted for age, sex, and standard mortality rates as its constituents. Half the DHAs in Inner London will experience further population decline over the next ten to twenty years. Under the internal market hospitals in the capital will have to attract contracts for their services as the funds available to Inner London purchasers fall.

Box 6.1

FUTURE DEMAND

- **There will be little or no increase in overall planned requirement for health care professionals, and more demand for less-qualified and unqualified health care staff (helper grades, health care assistants, support workers) and for technician grades, if plans to alter grade mix are implemented. Assessing the outcomes, in quality terms, of grade mix alterations will be given secondary priority to cost reductions.**
- **There are likely to be more redundancies and/or redeployment of professional staff, due to cost-containment pressures and grade mix alterations.**

Staff "following the patients"?

Analysis of DHA strategic plans and trust application documentation, discussions with management in London acute units and trusts, and the evidence of recent research on costs of health care provision in London, all suggest that there is unlikely to be a significant planned increase, in net terms, in met demand in the capital.

However, it is argued by most observers that higher costs – including the introduction of charges for capital assets and the impact of the purchaser/provider relationship with "money following the patient" – are likely to exert a downward pressure on the level of met demand for health care, particularly in Inner London. The internal market clearly provides purchasers with an incentive to place contracts elsewhere. There

Box 6.2

FUTURE SUPPLY

- **The health care sector in London will face competition for the diminishing pool of suitable qualified school leavers to enter pre-qualification training throughout the 1990s and beyond.**
- **There will be increased difficulties retaining health care professional staff in London in the face of growing competition from other employers, both in and outside the health care sector. Retention will be impaired, particularly if the level and scope of pre-qualification and post-basic training is curtailed, and if there is continued reliance on non-London recruits to training.**
- **The planned alteration in grade mix will require changed labour market strategies from health care employers in London. Increased demand for less-qualified and unqualified staff will focus greater efforts on recruiting from local labour markets. As such, labour market strategy and the promotion of equal opportunities will have to be coordinated and more attention will have to be paid to effective recruitment from ethnic minorities, on grounds both of equality and economy.**

is a strong possibility that to avoid these higher costs the geographical pattern of met demand will change, with a higher proportion being accommodated in the suburbs or the home region of patients currently travelling into London for treatment. It should be stressed that this scenario assumes that the purchaser/provider system will be fully implemented and that there will be no significant increase in, or changed allocation of, funding for public sector health care in London.

If this predicted change does occur, it will have significant implications for the current level of acute services in London and for the level and composition of the health care workforce in London. Will health care staff currently working in central London also have to "follow" patients – to suburban and regional provider sites?

Assuming that there is no significant increase in met demand, and that there is a shift in balance, with more services being provided in the suburbs and elsewhere, it is possible to make some broad predictions about future labour requirements in London. Depending upon the political climate, other factors which may have to be considered include: the likelihood of an upturn in the economy, with reduced unemployment; further and fuller development of devolved responsibility for employment policy and practice (by implementation of the third "wave" in April 1993, more than half of NHS units are planned to be trusts); an increased focus on labour costs, with cost containment a priority.

This scenario should not be taken as an indicator of "steady state" in net overall terms of demand or supply. The recently published government Green Paper on health targets could lead to a higher priority being given to health promotion (which could also mean a diversion of funds from the acute sector). Equally, fuller implementation of "care in the community" would also reduce pressure on the acute sector, with a likely increase in demand for health care staff in the community sector. The role of local authorities could become more prominent – primarily as purchasers of services, but also, potentially, as employers of health care staff currently employed in the NHS.

From the labour supply perspective, the devolution of responsibility to unit level in the NHS will not reduce the requirements for planning and coordination; indeed it is likely to have the opposite effect, as employing units flex their bargaining muscles and test the boundaries of their new-found "flexible" freedom.

The likelihood of the predicted events occurring should not be taken as any indication that they are necessarily regarded as desirable by all commentators. Furthermore, these changes may occur either as part of a planned strategy or in a piecemeal fashion, depending upon the existence, or otherwise, of a coordinated strategy for the acute sector in London.

It is evident that health care employers in Inner London districts have more in common with each other, in labour market terms, than they have with other districts within their respective RHAs. A greater coordination of labour market activities by units in Inner London is required on grounds of cost-effectiveness, and this is already occurring informally.

Some commentators are demanding a single regional authority

Box 6.3

FUTURE EMPLOYMENT POLICY AND PRACTICE

- **Informal or formal cartels of London health care employers are likely to develop, which will act to maintain the pay of health care professionals and other health-care-specific staff at a level below that which would be dictated by the free market.**
- **There will be increasing use of individual and "targeted" pay supplements, aimed at staff with specific skills and experience, and more use will be made of individual and team performance payments.**
- **There will be stimulus for greater use of non-pay incentives to recruitment and retention, particularly as a response to an "ageing" workforce, but cost constraints may lead to more targeting of these benefits to "hard-to-fill" posts and valued employees.**
- **The balance of employment between permanent staff and contract staff will alter. Health care employers will make greater use of contracted staff, not only in non-health care occupations, but also in relation to gaining contracts for the provision of specialised health care services.**
- **More use will be made of internal agencies and staff banks for temporary staff.**

for health care planning and monitoring purposes across London. If this were to occur it would be important to ensure coordination of labour market activities across the capital. If it does not occur, it is likely that informal cooperation between units sharing labour markets will become more evident and more formalised, and that this cooperation will increasingly become inter-regional rather than intra-regional, as the current administrative boundaries are ignored in favour of boundaries delineated by labour market pressures.

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King's Fund London Initiative

Working Paper No. 10

Health Care Labour Markets: Supply and change in London was prepared to inform the work of the King's Fund Commission on the Future of Acute Services in London. It is being published in advance of the Commission's strategy for London in order to inform debate about the future of health care in the capital. This paper should not, however, be interpreted as in any way anticipating the recommendations of the Commission's final report.

The King's Fund Commission on the Future of London's Acute Health Services' terms of reference require it to "develop a broad vision of the pattern of acute services that would make sense for London in the coming decade and the early years of the next century". With this in mind, the Fund's London Acute Services Initiative has undertaken a wide-ranging programme of research and information gathering on the Commission's behalf, of which this working paper represents one part.

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