GENERAL ELECTION

What health and care need from the next government

NHS staffing

Briefing 1

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nuffieldtrust

The NHS and social care in England are struggling. A combination of the sudden shocks from the Covid-19 pandemic and high inflation, and the longer-term pressures of poor workforce planning, morale problems, failure to deliver promised efficiency savings, and decades of delay to social care reform are all taking their toll. Strain and dysfunction are deeply rooted and will not immediately improve, and the public sees this clearly: satisfaction with both services is at historic lows. Credible long-term plans to improve this situation are vital for any political leader who wants to gain the support of the British people.

This series of briefings sets out particular issues where we believe there is clear evidence that a UK government taking or returning to office in the next year must act in order to meaningfully improve the English health and care system for which it is responsible. This is presented as a series of tests that a policy programme during the next Parliament should meet. They often address less visible, easily overlooked decisions that work behind the scenes to shape the care people experience. We hope these briefings will **inform** the public debate that MPs, journalists, experts and institutions shape over the coming months, and **influence** the policy formation decisions of the national political parties as they draw up a platform to put to the British people.

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Overview

The 1.7 million people who make up the workforce of the English NHS are its primary asset, its largest cost, and indispensable to everything it does. The British Social Attitudes survey has shown that staffing is the issue the public identifies most clearly as an important NHS priority, and the majority of people who were dissatisfied with the health service considered staffing to be a key reason. Getting the right workforce policies within overstretched health budgets will be crucial for political parties competing in this year's general election.

Expanding the numbers of clinical staff nationally is popular with the public. A long-term workforce plan to achieve this already exists, and all political parties can be expected to commit to more recruitment for one staff group or another. But it is also expensive, difficult, and can be slow – and there is a risk that if done too simplistically it will not be cost-effective, staff numbers won't grow in the areas or professions where they are sorely needed, or the workforce will continue to leave prematurely.

If the next government wants an NHS workforce that achieves more for patients and the public while also enforcing a tight financial envelope, there are a number of tests it must meet to improve processes and policy direction. Meeting these tests would require clear direction to be provided for the health sector, and restraint in committing before the evidence is clear. But they would not be intrinsically expensive, and many would probably be popular. We hope these will feature prominently in election commitments from all parties, and we will review the extent to which these vital issues are being addressed just ahead of the next election.

1. The NHS pay review process is in dire need of reform, and the next government must tackle this issue. It has not contained industrial strife and risks being abandoned by all sides. Pay review bodies need to publish their recommendations faster, be more able to address different financial realities, and be better informed by research so that they can actually try to deliver policy goals.

2. There are unacceptably high dropout rates at every stage of clinical education and early careers in the NHS. This risks wasting the large increases in training set out in the Long Term Workforce Plan. Student loans forgiveness and other rewards and incentives used in other countries should be adopted to target potential and new joiners at risk of rejecting the NHS and other public services. The next government must also make sure that opportunities to get placements where students and trainees learn from real work in NHS services keep up with the booming number of trainees.

3. New roles which take on some tasks traditionally done by doctors or by nurses, such as physician associates and nursing associates, must be rolled out safely and effectively. This requires an increase in the low level of public understanding; careful and appropriate regulation; and oversight to make sure NHS bodies are supervising them enough and using them for the right tasks, in a way that makes sense for local services.

4. The next government must tackle the postcode lottery in NHS staffing, and longstanding imbalances where some professions grow while equally vital ones stagnate. They should commit to precise goals to reduce staffing inequalities and make sure national and local decisions reflect these. They should find out which of the many policies in the UK and other countries aiming to pull staff to underserved areas actually work, expand these, and drop others.

5. The rate of staff leaving the service in general has been elevated since the pandemic, wasting experience and training and suggesting poor morale. The next government should build on earlier schemes to reduce leavers from trusts, and task national bodies with working out what would make them stay. There should be funded local plans to reduce sickness absence, and requirements on the NHS to make working life easier for parents.

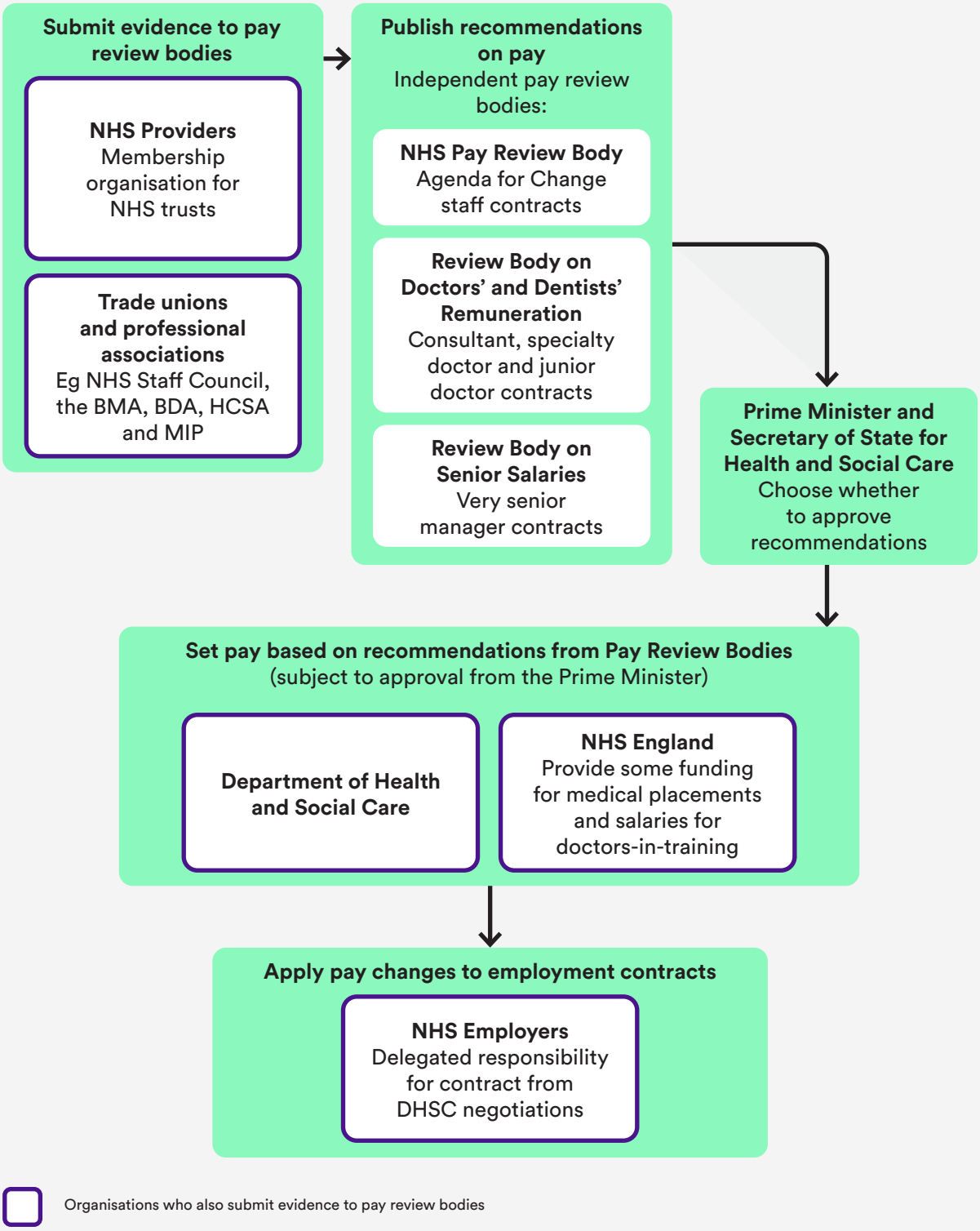
Test 1 Improve the NHS pay review process to ensure it is fit for purpose

The cost of employing staff accounts for around two-thirds of NHS expenditure, with NHS trusts spending some £72 billion on pay in the year to March 2022.[1] Pay is a tangible way to value staff. It influences whether the NHS can attract recruits from the UK and abroad, and keep the staff it has. While other factors are involved, pay has been the primary demand of trade unions during recent strikes.

In theory at least, the UK has an extensive and independent process to achieve fair pay settlements that balance the need to attract and retain more staff with health sector affordability. The pay review bodies consider evidence submitted to them from government, arm's length bodies, unions and others, before making recommendations to the UK governments on pay for NHS staff (see Figure 1).

1 NHS England (2023) *Consolidated NHS provider accounts 2021/22*.

Figure 1: Overview of the pay review process for NHS staff in England



However, the NHS has faced its most challenging and sustained period of industrial action since its inception. Dissatisfaction with pay and conditions has spanned all manner of professions working in the health service[2] and, in the case of doctors, strike action does not appear to be decelerating, with repeated strike action announced for both junior doctors and consultants.[3,4,] The published data suggest that, across the 42 days of strikes between December 2022 and August 2023, over 100,000 operations and nearly 800,000 outpatient appointments were rescheduled. If anything, this is likely to be an underestimate.[5]

This reflects a loss of faith in the successful functioning of the pay settlement system. Many unions are refusing to submit evidence to the pay review bodies because of a lack of trust.[6] The government has negotiated separately and has been very inconsistent in adopting the recommendations it receives in any case: around one in three NHS nurses' pay recommendations made by the body between 1984 and 2007 were either delayed or implemented in a staged manner.[7] While there might not be an obvious model for pay setting used elsewhere that can be simply adopted here, it is notable that governments in some of the other countries we have looked at often have a more limited role in the pay-setting process than has been the case here in recent years.[8]

2 NHS Staff Surveys (2023) *NHS Staff Survey 2022 national dashboards*.
3 British Medical Association (2023) *Junior doctors guide to strike action in England*.
4 British Medical Association (2023) *BMA secures extended mandate for consultants' industrial action in England as vote on pay offer continues*.
5 Scobie S (2023) *Are strikes by health care staff impacting NHS waiting lists?* Nuffield Trust.
6 Campbell D and Crerar P (2023) *Health unions refuse to give evidence to 'rigged' NHS pay review system*. The Guardian.
7 Buchan J, Charlesworth A, Bazeer N, Shembavnekar N and Kelly E (2022) *Where next for NHS nurses' pay?* The Health Foundation.
8 Nuffield Trust blog (in preparation)

There are many issues with the current process, including that:

- recommendations are **often late**, published several months into the financial year when they are supposed to take effect. While pay is backdated in these cases, such delays can cause real cost-of-living challenges for some staff – particularly against the backdrop of high inflation – and adds considerable financial uncertainty for employers.

- governments have **struggled to use multi-year deals successfully**. Longer-term pay offers could allow more creative and strategic approaches. However, they can also leave staff and government stranded with a settlement that no longer fits the circumstances. The multi-year deal for junior doctors set in 2019, limited to a 2% increase per annum, was set before the Covid-19 pandemic and when inflation was predicted to be running at around 2% a year. It was not revisited even as higher inflation meant junior doctor pay dropping sharply in real terms.[9]

- the absence of independent, timely analysis from the pay bodies has left a **shortage of up-to-date facts on pay** which is often filled by interested parties choosing inflation measures and comparators to advocate for their position rather than present a balanced picture.

- **affordability is typically considered narrowly** in terms of the Department of Health and Social Care budget rather than in the wider context of the public purse, meaning decisions are confined by allocations from the Treasury usually taken months or years earlier. A significant proportion of any additional pay is returned to HM Treasury through taxation and student loan repayments, but this is not considered.

- the **evidence base on the effects of pay on recruitment, retention, and participation is poor**. While available data to support such research are limited, it would be possible to carry out evaluations of the outcomes of changes in pay, as well as other non-pay factors, on recruitment and

9 Bank of England (2019) *Inflation Report – May 2019*.

retention. This would mean decisions could be based on actual estimates of what they will mean for the size and shape of the workforce.

- there is a **lack of consideration of how fair pay deals are *between* professions**, both in relative and absolute terms. Currently, England is second only to South Korea when calculating the size of the pay difference between specialist doctors and nurses.[10] There is a risk that, given there are over 20 times as many staff on the Agenda for Change contract than the consultant contract, affordability considerations are given more weight for the former, artificially reducing their chances of higher pay increases. Given the different demographics between staffing groups, this also has implications on the ethnicity pay gap and other measures of equity.

The challenges around setting pay are not likely to get easier. The substantial planned growth in NHS staff and students studying clinical degrees will have implications for pay – with more staff and students to retain and greater total costs. The intention to increasingly employ emerging roles such as physician associates will also require pay to be set fairly between professions.

What needs to happen?

There is no simple solution when it comes to addressing pay concerns, particularly during an extended period of industrial unrest. However, all staff and employers at least deserve a pay review process that is fit for purpose.

There have been some encouraging commitments made which focus on reforming the pay review process as part of the pay negotiations with different staff groups, including on timing, governance, and use of evidence.[11,12] The next government needs to be ambitious about these changes and expand

10 OECD (2024), "Health care resources", OECD Health Statistics (database), https://doi.org/10.1787/data-00541-en (accessed on 20 February 2024).

11 British Medical Association (2023) *Consultant pay offer*.

12 NHS Employers (2023) *Government and Agenda for Change trade unions 'offer in principle'*.

them into a full overhaul. Taking all the problems above together, we believe that the following would help to improve the situation:

1 Pay review body recommendations and offers should be published in advance of the start of the financial year.

2 The next government should instruct pay review bodies to consider longer-term pay deals. However, they should include a 'force majeure' clause so that the deal is reviewed if inflation or vacancy numbers are higher than a set level.

3 The next government should provide specific funding for the pay review bodies to undertake or commission independent, in-depth research on the effect of pay on different outcomes, including recruitment, retention, participation, and wellbeing. This should be used to base pay settlements on credible estimates of how they will affect the number of staff and their morale.

4 The affordability of pay deals should be considered in the context of the whole public purse, rather than narrowly in terms of departmental budgets, while still recognising the need to provide each individual department with as much certainty about the funding and cost pressures as is possible. The pay review bodies should also be explicit if an affordability envelope restricts them from recommending a pay deal that is necessary to attract and keep enough staff.

5 The remit of the pay review bodies should include the importance of fairness of pay between professions and staff characteristics.

A previous article by the Nuffield Trust has further detail advising how to improve the evidence base, pay distribution, and governance of the pay review bodies as a means to moving towards a better system that works for NHS staff, employers and government.[13]

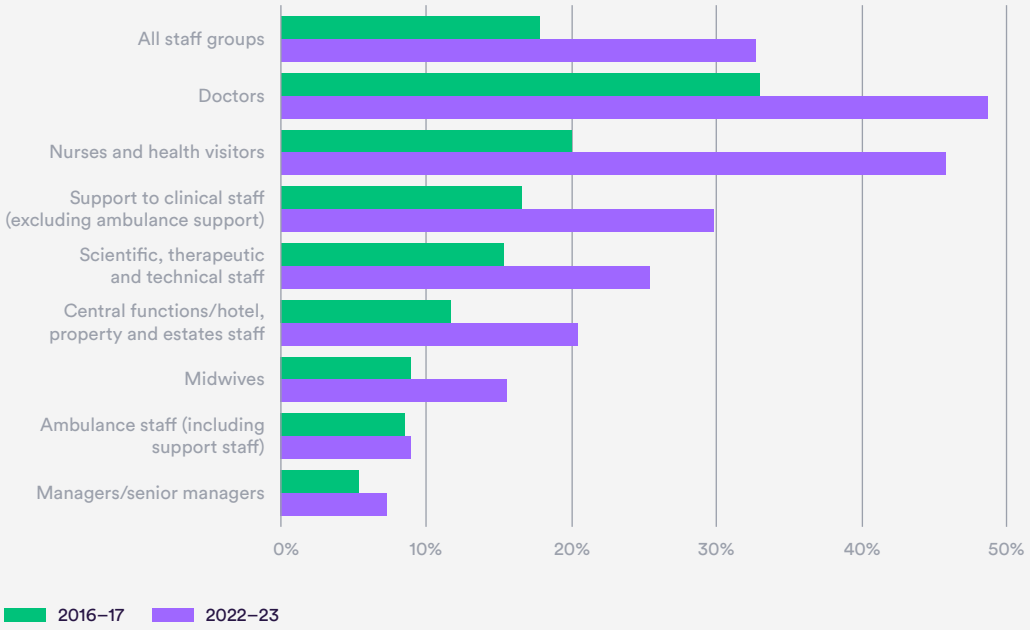
13 Palmer W (2023) *Basis of negotiation: recommendations to improve the NHS pay review process*. Nuffield Trust.

Test 2 Bring enough staff through domestic training to deliver a sustainable workforce

Growing the domestic supply of health care staff is critical to ensuring a long-term, sustainable solution to meet the rising demand for health care, as well as replacing staff who leave. In 2022, more than 83,000 students accepted a place to study a medical, nursing or other clinical degree across the UK. The cost of education – once postgraduate medical training is included – is over £5 billion annually.

The huge reliance of the NHS on international recruitment (see Figure 2) and increased levels of spending on agency workers demonstrate recent problems in the pipeline of homegrown clinicians. On the former, the proportion of non-UK workers joining the NHS has shifted from just under one in five (18%) in 2016–17 to a third (33%) in the year to June 2023. This proportion varies substantially when looking across staff groups, with nearly half (49%) of doctors and just 7% of managers with a non-UK nationality joining the NHS.

Figure 2: Proportion of staff joining NHS hospital and community services with a non-UK nationality



Notes: The chart shows the proportion of joiners to NHS hospital and community health services with a non-UK nationality by staff group. Ambulance support staff have been grouped with ambulance staff due to significant changes to the classification of ambulance staff in 2019.

Source: NHS Digital.

While we would expect some students and graduates to leave, the current levels of training attrition and staff quitting the NHS at the start of their careers are troubling, and represent an enormous loss:[14,15,16,17]

- Around one in five nurses (18%) have left NHS hospital and community employers within two years of starting work – with similar losses also

14 Garratt K (2023) *The NHS workforce in England*. House of Commons Library.
15 Palmer W, Rolewicz L and Dodsworth E (2023) *Waste not, want not: Strategies to improve the supply of clinical staff to the NHS*. Nuffield Trust.
16 Palmer W and Rolewicz L (2023) *All is not well: Sickness absence in the NHS in England*. Nuffield Trust.
17 Palmer W and Rolewicz L (2022) *Peak leaving? A spotlight on nurse leaver rates in the UK*. Nuffield Trust.

apparent for other key health professions. This rises to one in three within five years.[18]

- Around one in eight nursing (13%) and radiography (13%) students do not gain their intended degree, according to data from 2014 to 2020. This is not simply an inevitable result of a proportion of students changing their mind about continuing their courses: dropouts are far lower, for example, in physiotherapy (5%).

- There has been a fall in the number of students accepted onto nursing courses in England, representing a decrease of 4,620 (or 20%) since the peak in 2021.[19] Concerningly, the number of new nurses with a UK nationality joining NHS hospital and community services in the year to March 2022 was a third (6,325 or 32%) lower than two years prior.

The NHS's Long Term Workforce Plan, published in 2023, was a necessary step. The large increase in training places it proposes, including 92% more adult nursing places and double the number of medical school places by 2032, is broadly endorsed by both the current government and the opposition.[20,21]

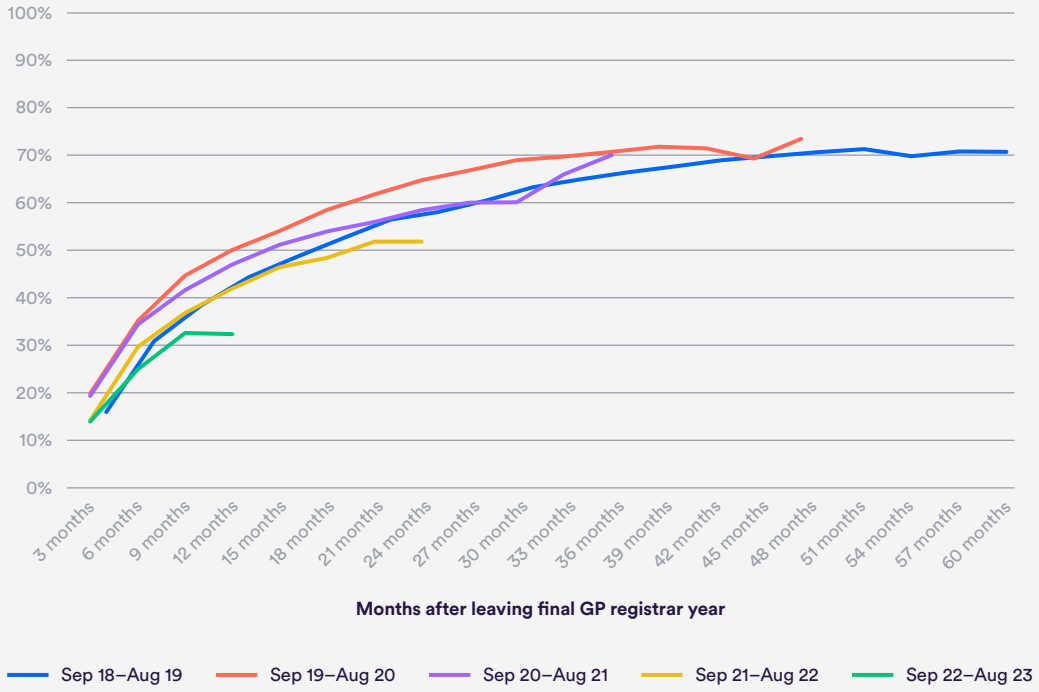
However, recent research suggests that there remains a need to encourage a broader pool of people, particularly from lower socioeconomic backgrounds, to embark on a clinical career.[22] Not only is there a clear moral case for this, but evidence suggests that widening access can lead to a more diverse and inclusive workforce, and ultimately improves quality of care for patients.[23]

That said, an increase to training places is not in itself sufficient without keeping people in those courses and ensuring they want to work in the NHS after graduation. The recent large expansion in the number of GP training places actually had little effect on the fully qualified, permanent GP workforce,

18 Palmer W, Rolewicz L and Dodsworth E (2023) *Waste not, want not: Strategies to improve the supply of clinical staff to the NHS*. Nuffield Trust.
19 UCAS (2023) *Statistical releases – daily clearing analysis 2023*.
20 NHS England (2023) *NHS Long Term Workforce Plan*.
21 Labour Party (2023) *Build an NHS fit for the future*.
22 Dodsworth E (2024) *How can we improve access to healthcare careers?* Universities UK.
23 Hemmings N, Buckingham H, Oung C and Palmer W (2021) *Attracting, supporting and retaining a diverse NHS workforce*. Nuffield Trust.

with many not joining the NHS upon completion of training (see Figure 3). In fact, the number of GPs continues to fall.[24]

Figure 3: Proportion of GP registrars ending their final year of placement taking up a fully qualified GP role in NHS general practices



Notes: The proportion of ST3 GP registrars who transitioned into the fully qualified GP workforce include GP partners, salaried GPs, regular locums and GP retainers. GPs working exclusively as ad-hoc locums or in, for example, out-of-hours, 111 or A&E streaming are not captured so the proportions are likely to represent an underestimate.

Source: Nuffield Trust analysis of NHS Digital data.

The plan also does not make fully clear how clinical placements would be expanded. Poor placement experience is a common reason for students leaving their course prematurely,[25] so availability and quality need to be not only maintained but expanded as trainees increase.[26]

Clinical training courses typically have entry requirements for academic attainment, as well as demonstrating skills in the application and interview

24 Nuffield Trust (2023) *How many GPs are there in England?*

25 Health Education England (2018) *RePAIR: Reducing Pre-registration Attrition and Improving Retention Report*.

26 Council of Deans of Health (2023) *A step change for a sustainable NHS workforce: General Election 2024*.

to ensure candidates are the right fit for a career in health care. There is a real risk that course entry requirement thresholds may be lowered to allow for more applicants to clinical courses being accepted in the future, particularly if the focus is on expanding training places by around two-thirds within the next decade.

The NHS Long Term Workforce Plan has also committed to increased use of apprenticeships – from fewer than 6,000 in 2022 to nearly 29,000 in 2031. These have the potential to improve attrition and provide more opportunities to people from more diverse backgrounds.[5] While the use and transfer of apprenticeship levy funds has marginally improved across NHS trusts in recent years,[27] there is still limited recognition of the challenges for organisations in delivering them and limited understanding of their impact on the workforce in the long term.

What needs to happen?

To maximise the benefits of the plans to increase the number of homegrown clinicians, we recommend the following:

1 The next government should set up a comprehensive campaign with the NHS and higher education providers to **attract a broader, more diverse pool of applicants** to a career in the health service. The campaign should cover media marketing and school engagement and include spreading awareness of different entry routes and requirements, the support available during training, and options to have a portfolio career within the public sector. It will also need to work with all stakeholders to ensure that the benefits of health care careers are clearly and widely articulated, with a particular focus on encouraging those from underrepresented groups.

2 The next government needs to ensure – as a critical next step for implementing the NHS Long-Term Workforce Plan – that there is a feasible **plan for increasing the clinical placement capacity** in step with the rapid expansion of training places. This will require strategies to appropriately value and incentivise individual educators and their organisations, and the use, where appropriate, of remote and simulated learning. Integrated Care

27 BPP (2023) *The NHS Apprenticeship Levy Study: the 2022 edition*.

Boards should be told to draw up local strategies on the distribution of placements across services and sectors.

3 The next government should formally evaluate the bolder measures that other countries use to secure and keep trainees and adopt those that seem promising. This should include a policy of **forgiving or delaying student loan repayments** as an incentive for recent graduates to commit to and continue working in the NHS or other eligible public services. The possible shape, costs and key advantages for this are outlined in the box below. The evaluation should also feed into the development and implementation of the tie-in scheme for dentists as proposed in the NHS's Long Term Workforce Plan.

4 The next government should commission an independent review on degree-level clinical **apprenticeships**, including evaluating funding models, challenges of delivery, and the impact of apprenticeship routes on inclusion, retention and participation.

Policy proposal: To increase applications to study, reduce attrition during training and improve participation and retention in public services on qualifying, a student loans forgiveness scheme for clinical graduates taking up employment in the NHS or other relevant public services could introduce a policy of student loans being written off after, say, 10 years of eligible service. The estimated cost would be somewhere in the region of £230 million for nurses, midwives and allied health professionals per cohort in England. The policy could also be expanded to doctors (costing in the region of an additional £170 million per cohort). Key advantages of this approach include that it is specifically targeted at new starters most vulnerable to not joining the NHS or to leaving, unlike general pay uplifts. There is also evidence showing people tend to weight student debt particularly highly as a cost relative to the objective costs. Recent polling by Censuswide of young people considering university courses for the Nuffield Trust and Universities UK found that financial concerns were prominent in putting them off, and 73% said that having some or all tuition fees written off after starting work in the NHS would make them more likely to choose to study a health care course.

Test 3 Make sure the deployment of different professional groups in the NHS is safe and efficient

The NHS workforce is made up of a huge array of professions – in hospital and community settings there are some 283 different role titles.[28] Introducing new professions, using professionals in new positions, and changing the skills they have and the tasks they do is a potential solution for many problems. It can help harness opportunities offered by new technologies and medical development, meet the changing needs of patients, improve cost-effectiveness, and keep up with rising demand. In recent years, this has been an area of rapid change. New roles which take on some tasks traditionally done by doctors or by nurses, such as physician associates and nursing associates, have proliferated across England.

But the introduction of new roles does not guarantee a better standard of care or a better experience of care. If poorly designed and implemented, changes in the mix of staff can increase demand, cost more, threaten the standard of treatment, and fragment care.[29] High-profile cases of patients dying after being

28 NHS Digital (2021) *HCHS staff by Org Staff Group, Job Role and Area of Work, Sep-20 AH3623*.

29 Imison C, Castle-Clarke S and Watson R (2016) *Reshaping the workforce to deliver the care patients need*. Nuffield Trust.

managed by staff in new professional roles[30] have raised concerns among NHS staff and risk the loss of public confidence.

Getting it right is difficult. There is no single one-size-fits-all ideal mix of health personnel.[31] NHS organisations need a deep understanding of their patients' needs to train and recruit the workforce accordingly[32] – a tall order for the many which have squeezed leadership and management capacity.[33]

While regulation of health and social care professions does not guarantee the complete avoidance of harm, it is intended to protect the public as much as possible from such risks and maintain public confidence. However, regulators are playing catch-up with the emergence of new roles. Some action is being taken, including anaesthesia and physician associates being brought into the scope of General Medical Council (GMC) registration by the end of 2024. However, taking the example of advanced clinical practitioners,[34] a group which is predicted to grow four-fold by 2036:

- the UK currently has no specific advanced practice regulation, unlike most nations with similar advanced practice level[35]

- patients' understanding of advanced practice could undermine trust in, and even consent to, treatment, with two in five (42%) trainee and

30 BBC News (2023) *Call for physician associate clarity after misdiagnosis death*.
31 Buchan J and Dal Poz M (2002) *Skill Mix in the Health Care Workforce*. Bulletin of the World Health Organization.
32 Imison C, Castle-Clarke S and Watson R (2016) *Reshaping the workforce to deliver the care patients* need. Nuffield Trust.
33 Rosen R and Palmer W (2023) *More staff in general practice, but is the emerging mix of roles what's needed?* Nuffield Trust.
34 Where nurses and other clinicians take on more complex, autonomous and expert roles.
35 Palmer W, Julian S and Vaughan L (2023) *Independent report on the regulation of advanced practice in nursing and midwifery*. Nuffield Trust.

advanced clinical practitioners in England reporting they thought that patients did not understand their role[36]

- there are examples of practitioners using the 'advanced practice' title despite, for example, failing to complete the full master's degree or attending only a half-day course.[37]

Resistance to these changes has been created at times because existing staff groups worry they are being substituted and will be replaced, and that new roles are only being introduced to save money.[38] The lack of attention paid to fairness of pay across professions, with some new roles having relatively high starting salaries compared to established professions (even if their subsequent pay progression opportunities are lower), risks worsening tensions.

Another cause of professional resistance stems from different professions potentially competing for the same limited educational opportunities. There is a risk this will worsen if plans to scale up training mean that there are even more people who need the opportunity to learn from undertaking procedures and processes in the NHS. There are challenges in ensuring sufficient clinical oversight and accountability as well as supervision. Eight years ago, for every fully qualified, permanent GP there was one other type of clinician in general practice, but now there are well over twice as many other clinicians.

The current funding arrangements may be distorting local decisions on skill mix. In particular, NHS trusts are incentivised to plan to use junior doctors rather than other staff, because NHS England covers half of the basic salary costs of doctors-in-training – and all for GPs – with further national funding for their training placements. This means, for instance, the direct costs to an NHS trust of employing a nurse are around four times that of a newly qualified

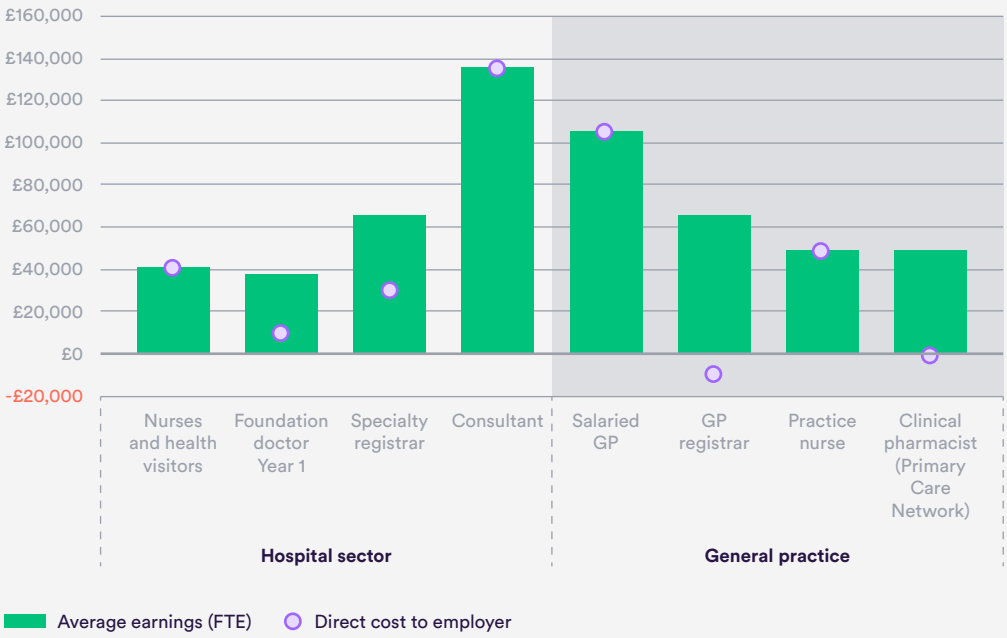
36 Lawler J, Radford M, Leary A and Maxwell E (2021) *Advanced clinical practitioners' experience of establishing a workplace jurisdiction*. International Journal of Healthcare Management 15(10), 1–9.

37 Palmer W, Julian S and Vaughan L (2023) *Independent report on the regulation of advanced practice in nursing and midwifery*. Nuffield Trust.

38 Imison C, Castle-Clarke S and Watson R (2016) *Reshaping the workforce to deliver the care patients need*. Nuffield Trust.

doctor, and similar to a specialty registrar (see Figure 4).[39,40] In general practice, two-thirds (63%) of the growth in staff over the last four years has been through the additional roles reimbursement scheme (ARRS), which means practices do not have to cover their salaries, but this arrangement only covers certain staff groups.

Figure 4: Average earnings and direct cost to employers of selected professions employed by NHS trusts or in general practice



Notes: We were not able to identify definitive data on general practice staff salaries and reimbursement, so these figures should be treated with caution. Due to lack of information, we could not factor in costs of supervision and training, which will differ between staff groups.

Source: Nuffield Trust analysis of NHS Digital data.

39 Data are for the lowest pay point for first-year foundation doctors, consultants and band 5 nurses. They include only basic salary costs and Health Education England placement fees. They exclude additional costs such as National Insurance and pension contributions, payments for working unsocial hours or on call, and overheads. Figures are rounded to the nearest £100.

40 National Audit Office (2016) *Managing the supply of NHS clinical staff in England*.

What needs to happen?

Rapid changes are already in progress, and recent policy has moved forward in recognising that a one-size-fits-all model for staffing will not work, with smaller hospitals (for example) needing different staff.[41] The next government should focus on making sure that national policy is helping the NHS locally to get a safe, productive mix of staff, rather than getting in the way:

1 National bodies should be told to look further into whether heavy subsidies to trusts for employers training junior doctors, rather than nurses or other staff, are distorting the types of staff trusts take on. They should investigate rebalancing the funding attached to training to ensure it accurately reflects the actual costs of training different professions. This could mean considering an overall shift of funding from medical training to nursing and other groups.

2 The next government should work with professional bodies, patient groups and others to make urgent progress to ensure appropriate regulation – whether statutory or not – is in place for emerging staff groups. While this is under way for physician associates, not covering some of these roles or making progress too slowly risks losing public confidence and failing to build any awareness.

3 Working with partners and using the appropriate departmental and NHS England communications teams, the government should launch an extensive communications campaign programme to improve public recognition and understanding of different roles. They should draw up consistent ways that NHS staff can tell patients about what new roles do when they meet them. People should know and understand who is treating them, and have a rough idea of their skills and responsibilities.

41 NHS England (2023) *NHS Long Term Workforce Plan*.

Test 4 Eliminate the postcode lottery of NHS staff between services, settings and regions

The current government achieved some of its headline workforce ambitions pledged during the 2019 general election, such as adding 50,000 more nurses[42] and 26,000 more non-medical clinicians in general practice.[43] But for patients and individual services, what matters is not national staffing totals but whether they have the right staff where they are. Polling shows the public strongly believe that ability to get treatment should not vary across England.[44] Although national staffing numbers are very important, particular settings and areas of the country can benefit disproportionately from changes. A clear example of this is the persistent variation in the number of GPs between regions, even when taking account of patient need, ranging from 2,702 patients per GP in Kent and Medway compared to 1,868 in Gloucestershire (Figure 5). Similarly, in dentistry, across 106 local health economies (sub-Integrated Care Board areas) there is a three-fold variation in the number of dentists per head carrying out NHS activity in England.[45]

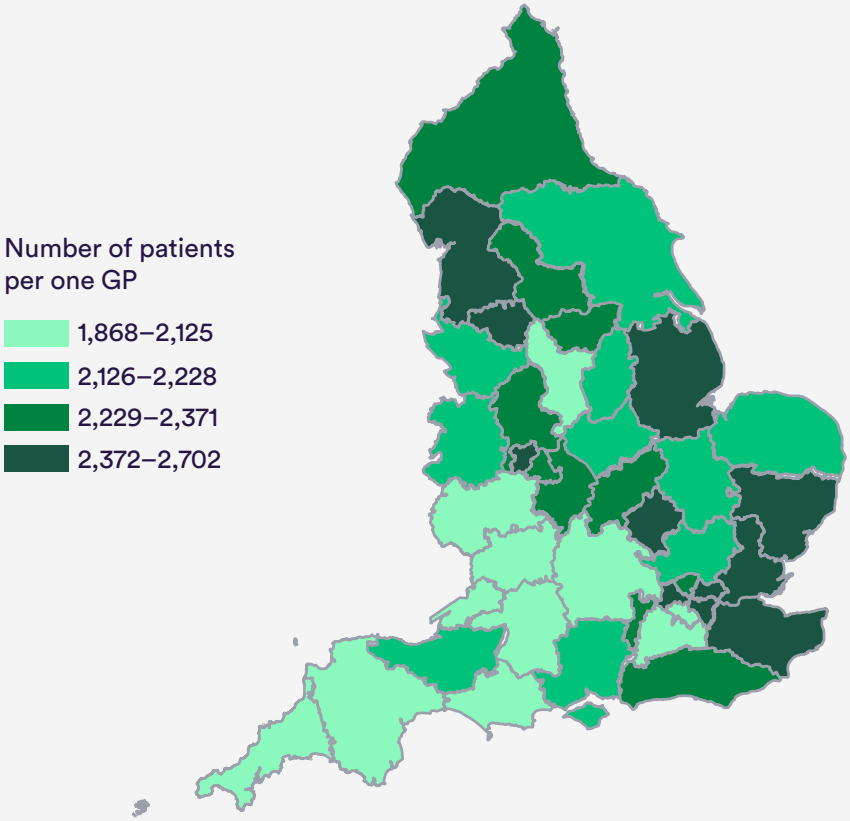
42 Rolewicz L (2023) *The past, present and future of NHS nurse numbers*. Nuffield Trust.

43 Department of Health and Social Care (2023) *Boosting the primary care workforce and improving patient experience*.

44 Wellings D (2017) *What does the public think about the NHS?* The King's Fund.

45 Williams W, Fisher E and Edwards N (2023) *Bold action or slow decay? The state of NHS dentistry and future policy actions*. Nuffield Trust.

Figure 5: Number of patients per one GP by Integrated Care Board (ICB)



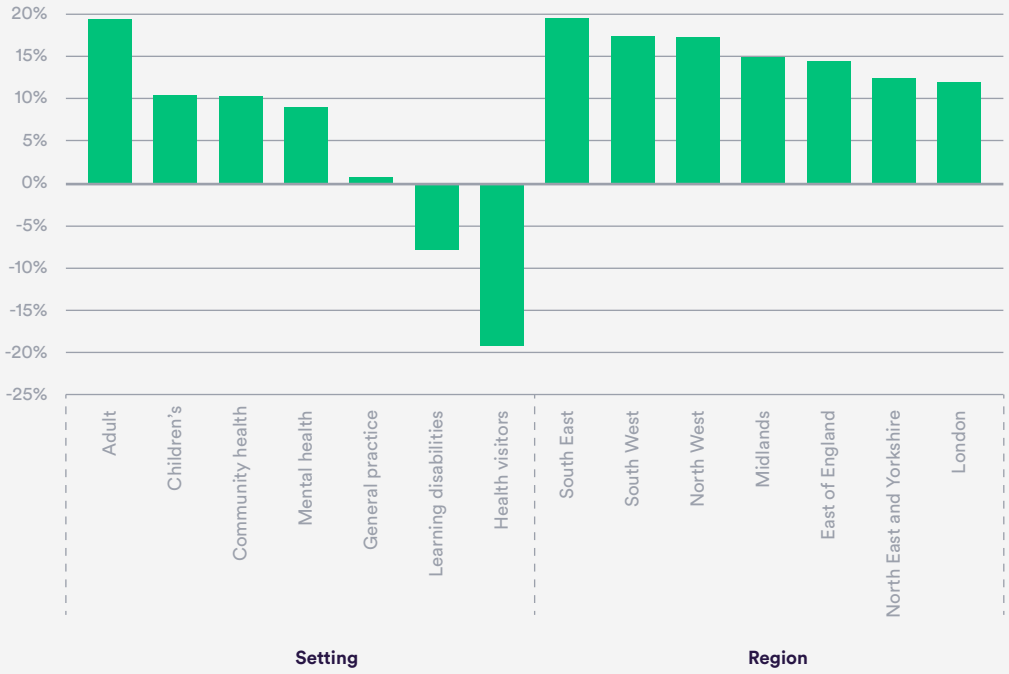
Notes: Data compares the number of full-time equivalent GPs as of June 2023 with needs-weighted population by ICB.

Source: Nuffield Trust analysis of data from NHS Digital and NHS England.

Similarly, in nursing, there has been an increase among those working in adult and children's settings in 2023 relative to 13 years prior (by 31% and 72% respectively), but the number of learning disability nurses has nearly halved over the same period (equivalent to a fall of 44%). Even more recently, the increases in nurses over this Parliament have varied substantially between:

- Areas of the country – with a near two-fold difference even at regional level
- Branches of nursing, with a 20% increase in adult nurses nearly mirroring (albeit in the opposite direction) a 19% fall in health visitors (Figure 6).

Figure 6: Change in the number of nurses in hospital, community and general practice settings, December 2019 to September 2023



Notes: Regional differences exclude health visitors.

Source: Nuffield Trust analysis of NHS Digital data.

Differences in the distribution of staff according to need suggest that patients with some illnesses and in certain places arbitrarily find fewer people to treat their problems. In some cases, particularly general practice, there is actually evidence that people needing most care have the least staff in their area – potentially making gaps in health and mortality worse and working against the goal of 'levelling up'.[46,47]

Some positive changes have been made to work towards a fairer distribution of staff, with the expansion of medical school places including through new medical schools being allocated to areas based on need. This is important given that around a quarter of doctors stay within 10 miles of the medical school that they trained in. Not only this, but areas such as Portsmouth are

46 Fisher R, Allen L, Malhotra AM and Alderwick H (2022) *Tackling the inverse care law*. The Health Foundation.

47 HM Government (2022) *Levelling Up the United Kingdom*.

working on their own local initiatives to deliver more medical education within the city, in response to addressing the local shortage of GPs.[48] Specialist subjects that struggle to recruit, such as learning disability nursing courses, offer additional grant payments for those starting training.[49]

There are also initiatives in place to attract NHS staff to work in specific areas, particularly those with high deprivation, rurality or higher levels of understaffing. Supplementary 'recruitment and retention premia', paid in areas with a greater need for staff, are an example of a way to ensure a fairer distribution of the workforce. But they are rarely and unevenly used, with little research on what motivates uptake. On average, doctors in receipt of premia were paid £18,000 a year – 21% of their mean earnings – compared to £1,900 for clinical support staff, equating to 9% of their mean earnings.[50]

National premia schemes also exist, such as the Targeted Enhanced Recruitment Scheme, which offers £20,000 to GP trainees taking up posts in underserved areas.[51] More informally, employing organisations can advertise jobs at higher bands or pay points.

But none of these mechanisms are well understood, with little known about their attractiveness to prospective applicants and their short- and long-term impact on retention. For geographical allowances such as London weighting, it remains unclear whether the intention behind it is to reimburse for the higher cost of living, or to address staffing shortages in those areas in and around London.

48 University of Portsmouth (2023) *Portsmouth to begin training its own doctors*.

49 Department of Health and Social Care (2019) *Nursing students to receive £5,000 payment a year*.

50 Rolewicz L and Palmer W (2022) *Placed at a premium? The use of recruitment and retention pay supplements to address staffing shortfalls*. Nuffield Trust.

51 NHS England (2023) *Targeted Enhanced Recruitment Scheme (TERS)*.

What needs to happen?

The NHS has multiple schemes to address staffing-level disparities between areas and settings. However, in many cases the disparities are wide and are, if anything, worsening in some groups, which suggests they are not fully working. The bulk of the work must be done by NHS employers and local Integrated Care Boards, but the next government should support and incentivise them in the following ways:

1 The next government should commit to precise goals to reduce disparities in staffing, specify these to national and local NHS bodies in the various forms of guidance and instruction it issues, and set out what each of the pay measures to address them is supposed to be achieving.

2 They should commission evaluations on whether existing schemes to reduce differences in recruitment and retention are working. These should look at whether they are attractive for prospective applicants; whether they actually increase staff retention in a given area; whether they have benefits which outweigh the cost; and whether they have any unintended consequences on other areas, staff groups and characteristics.

3 Working with a team of civil servants or commissioning research externally, the government must identify and share best practice of the use of premia across different sectors, as well as drawing on examples from other UK nations. This should include any research on the motivations behind staff taking up these payments, and an understanding of what sort of non-pay incentives are valued.

4 As the government and NHS England oversee the necessary expansion of clinical training and increased use of apprenticeships, they should use the distribution of new education places to get people to work in understaffed areas and specialties.

5 The next government should also commit to ensuring a fairer distribution of dentists, with improved access to NHS dentistry in currently underserved regions a key aspect of the fundamental reforms of the dental contract which are urgently needed.

Test 5 Retain as many as possible of the valuable staff currently working in the NHS

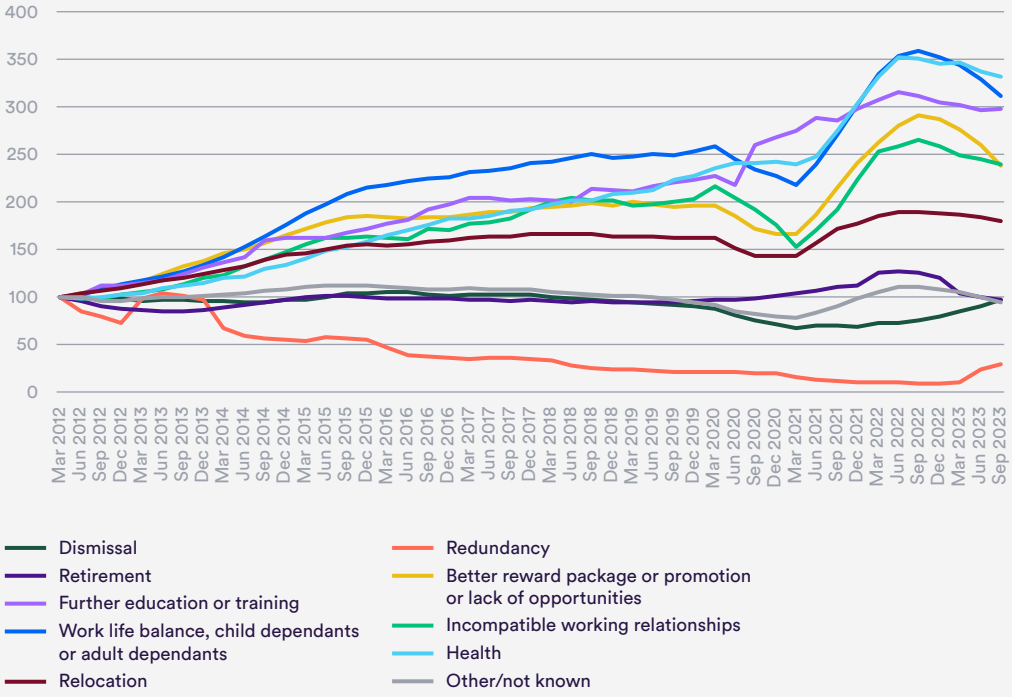
In the year to September 2022, English NHS hospital and community services saw a record number and proportion of staff exits, with around 172,000 leaving active service, equivalent to one in eight (12.5%). While the leaver rate decreased the following year, more can be done to retain the NHS's valuable staff. While some level of leaving is to be expected, an undesirably high rate results in staffing gaps, compounded by a loss of knowledge and experience which benefit patients. Apart from helping to secure a workforce that is large enough and skilled enough, keeping more existing staff in the NHS would be a sign of improved wellbeing at work and would reduce the burden of recruitment on the health service.[52]

Information on why staff leave is limited. The available NHS data – which includes those moving between NHS organisations – shows that retirement is the most commonly given single reason. But since 2011/12, the numbers pointing to health and work-life balance as reasons to leave have all roughly tripled (see Figure 7). Those who have left citing a lack of opportunities, wanting better rewards packages or to undertake further education or training have all more than doubled. Reviews of the global literature show a similar picture, highlighting job satisfaction, career development and work–life balance as the main determinants of retention.[53]

52 Palmer W and Rolewicz L (2022) *Peak leaving? A spotlight on nurse leaver rates in the UK*. Nuffield Trust.

53 De Vries N, Boone A, Godderis L *et al* (2023). *The Race to Retain Healthcare Workers: A Systematic Review on Factors that Impact Retention of Nurses and Physicians in Hospitals*. INQUIRY: The Journal of Health Care Organization, Provision, and Financing.

Figure 7: Reasons for NHS staff leaving their role, indexed to 2011/12



Notes: Data is presented as a 12-month rolling average, indexed to 2011/12 and includes staff moving between NHS organisations, as well as those leaving the NHS entirely.

Source: Nuffield Trust analysis of NHS Digital data.

Negative workplace culture appears to be another key determinant of staff leaving. This reason appears prominently in reasons cited by nurses for leaving the nursing register.[54] In wider NHS data there has been a doubling in the last 12 years of staff citing 'incompatible working relationships' as reasons for leaving.[55] Reported levels of discrimination (experienced by 9% of staff in the last year) and bullying, harassment or abuse from colleagues (experienced by 19%) remain troublingly high. The 2021 Messenger review of NHS leadership warned that poor behaviour and culture reflected "an institutional

54 Nursing & Midwifery Council (2022) *Leavers' survey 2022*.

55 NHS Digital (2023) *NHS Workforce Statistics – June 2023 (Including selected provisional statistics for July 2023)*.

inadequacy in the way that leadership and management is trained, developed and valued".[56]

The mental and physical health of staff is also feeding into increased leaver rates. A nurse or midwife who missed three days of work for mental health reasons was 27% more likely to leave three months later than a peer with no absences.[57] While there will always be instances when some staff become unwell and are unable to work, it is concerning that sickness absence levels remain high, particularly as staff absences are estimated to cost the NHS £3.8 billion a year.[58,59]

The NHS Long Term Workforce Plan has bold ambitions around decreasing leaver rates. Specifically, the aim is to reduce the overall leaver rate for NHS-employed staff from 9.1% in 2022 to between 7.4% and 8.2% by 2036/37, which is equivalent to 55,000 to 128,000 full-time staff.[60] A previous national programme to improve retention of nurses does provide some hope. The initiative, which was in place prior to the Covid-19 pandemic, saw hospitals provided with a data pack, central collaborator and some guidelines (but no numeric targets). It was estimated to have reduced the numbers leaving the public hospital sector by 5% and was associated with a decrease in patient mortality.[61]

56 Department of Health and Social Care (2022) *Leadership for a collaborative and inclusive future*.
57 Kelly E, Stoye G and Warner M (2022) *Factors associated with staff retention in the NHS acute sector*. Institute for Fiscal Studies.
58 NHS Digital (2023) *NHS Sickness Absence Rates*.
59 Daniels K, Connolly S, Woodard R et al (2022) *NHS staff wellbeing: Why investing in organisational and management practices makes business sense*. EPPI Centre.
60 NHS England (2023) *NHS Long Term Workforce Plan*.
61 University of Surrey (2023) *NHS retention programme prevents 11,400 deaths, finds new study*.

What needs to happen?

The limited evidence on drivers of staff leaving and on solutions suggests that in order to deliver a sustained improvement:

1 The next government must urgently improve the data and insights available on reasons for leaving, including how these differ by staff group, characteristics and demographics, and ensure that insights are made available for regional and local oversight.

2 They must make sure that training not only develops the clinical skills required in the future but also the core managerial and leadership skills that are needed to develop and sustain positive frontline working cultures.

3 The next government must ensure that NHS England and Integrated Care Boards lead by example to improve organisational culture across the whole NHS. This includes adopting a standardised framework for cultural values, including training on promoting equal opportunities and fair and inclusive leadership practices, at every career level.

4 They should look to continue the rollout of successful initiatives to retain nurses, consider expanding the scope to other staff groups and ensure that all groups, including different nationalities, ethnicities and ages, are fully considered.

5 A future government should provide specific funding to commission independent, in-depth research on the effect on retention of various reward, staff engagement and flexible working options, including how these are prioritised by staff. This research should explore differences between staff groups and demographics, including those yet to join the NHS such as those still in education.

6 The government must ensure that there are sufficient local resources to develop, and deliver on, plans to better manage sickness absence. This should allow employers to introduce proactive measures such as better management of working schedules, more access to peer-to-peer support networks and improving the physical working environment. Working

alongside staff, organisation leaders should also develop better 'return to work' policies for those who do need to take a leave of absence, through promoting more flexible working and ensuring appropriate workplace adjustments are in place.

7 The next government should encourage employers to make sure that parents are not driven to leave the NHS because of the requirements of training and for career progression, or because of a lack of childcare or flexible shifts.

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

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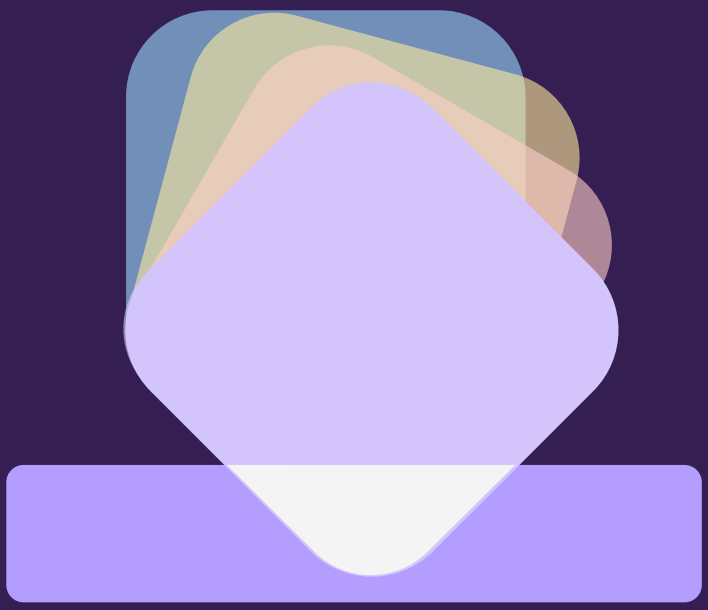

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