

# Partial review of the Shortage Occupation List

Review of nursing

Migration Advisory Committee

March 2016



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## Chairman's foreword



### Context

A year ago, the Migration Advisory Committee (MAC) reviewed part of the shortage occupation list (SOL). This is a list of job titles and occupations, which have priority for Tier 2 work visas for skilled non-EEA nationals. A further advantage of being on the SOL is that workers in such jobs do not have to earn the minimum £35,000 pay threshold which will be required from April this year to remain in the UK for longer than 5 years (indefinite leave to remain).

Last year, the Department of Health (DH) did not request nurses be put on the SOL. The MAC assumed, probably erroneously, that DH knows more about the nurse labour market than the MAC does, so did not recommend that nurses be added to the SOL.

During 2015, DH altered its view. In order not to put the health of the nation at risk, the Home Secretary added nurses to the SOL in October pending a MAC review.

The Nursing and Midwifery Council (NMC), the professional regulatory body for nurses and midwives in the UK, is responsible for the registration of all UK nurses. It recognises four fields of registered nurse: adult; mental health; learning disabilities; children.

In England, there were 361,000 nurses working in the NHS in 2015. But in the UK as a whole – NHS plus the care and independent health sectors – over 600,000 nurses are employed. Nurse numbers have increased in the last 3 years. OECD put the proportion of foreign-born nurses in the UK in total employment at 22% in 2011, up from 15% in 2001. Currently, the corresponding OECD nursing average is 15%. In 2014-15, 8,000 foreign-born nurses were recruited, mainly from the EEA.

In order to be placed on the SOL an occupation must pass three hurdles: is it skilled to the required level? Is it in shortage? Is it sensible to fill vacancies with non-EEA labour? These will be considered in turn. I conclude with some observations concerning the nursing workforce that require urgent attention from DH and related bodies.

## **Skill**

The requisite skill level for inclusion on the SOL is National Qualifications Framework level 6 and above (NQF6+), i.e. graduate level. Nurses (standard occupation code (SOC) 2231) are skilled to NQF6+.

## **Shortage**

### Evidence from national data and partners

Nurses pass 5 of the 7 MAC top-down (i.e. national data) indicators of shortage. These cover employment, hours worked and skill shortage vacancies. There are also 3 pay indicators but these are not relevant at a time of pay freeze or severe public sector pay restraint.

The National Institute for Health and Care Excellence (NICE) guidance indicates that organizations should aim for a maximum 5% vacancy rate to accommodate operational flexibility needs. Health Education England (HEE), the body responsible for workforce planning for the NHS in England, estimates the current nurse vacancy rate in England at 9.4%, nearly double the NICE guideline. And in London, the RCN put the rate at 17%. Partner evidence suggests vacancy rates well above 5% in the care sector too.

Nurses' pay accounts for about one tenth of NHS expenditure in England. In turn, spending on agency nurses is equivalent to one tenth of the nurse pay bill. Therefore, agency nurse spending – some 1% of NHS spending – should not be exaggerated. Nevertheless, such spending has risen rapidly in recent years. This is a further reflection of a nurse shortage.

National data and evidence from employers and trade unions therefore strongly suggests a shortage of nurses. Why?

### Demand for nurses

Four main factors have boosted the demand for nurses in recent years. It is emphasised that the first three below should surely have been anticipated by those responsible for workforce planning:

- Population: the total population is rising and, in addition, people are living longer and therefore require more nursing care;
- Reforms: moves to integrate NHS and social care, coupled with an emphasis on 7 day working, raise demand;
- Changing role of nurses: nurses have taken on more responsibilities, including some duties previously carried out by doctors;
- Francis report and staffing guidelines: demand for nurses rose as trusts sought to increase the nurse-to-patient ratios in response to the 2013 Francis report into events at Mid-Staffordshire NHS trust.

### Supply side

Supply is influenced by workforce planning, training places and retention efforts. Again, these are matters within the control of DH or individual employers:

- Workforce planning: in England this involves aggregating local workforce plans into a national plan. The National Audit Office recently commented that this overlooks systemic changes in how services are delivered and suggested that a more co-ordinated and proactive approach to managing the supply of staff could result in efficiencies for the NHS as a whole;
- Training: between 2009/10 and 2012/13 the volume of nurse commissions (training places) fell by around a fifth, some 5,000 places. This trend has been partially reversed recently. The number of places would be substantially higher but for financial pressures;
- Move away from bursaries to a student loan system: in principle this is a sensible policy, but public sector pay restraint may limit the numbers prepared to take up the extra places provided by universities;
- Retention: nurse turnover trended from 7.8% in 2008-09 to 9.3% in 2014-15. There is now a noticeable spike in retirements at 55, the earliest age at which a nurse can retire on full NHS pension benefits. Considerable effort is being made to retain nurses. Local initiatives include flexible working, skills development and use of pay supplements.

### Pay

Pay is a lever at the disposal of public sector employers to moderate shortages. If it is not used, the tension in policy objectives between restraining public spending and cutting immigration comes to the fore.

- Median pay for nurses is £31,500. This is £7,500 below the median pay in other graduate occupations;
- There was a severe nurse shortage in the late 1990s and early 2000s. The Pay Review Body responded with substantial real pay increases. There is no sign of this happening now, nor of DH requesting such action;
- Available pay flexibility is insufficiently used. Possible adjustments include recruitment and retention premia and a market forces factor reflecting cost differences among health care providers.

### **Sensible**

Over the next decade, the shortage of nurses can be addressed by more training places, reduced attrition (wastage) among trainees, greater efforts at return to

practice, more innovative use of pay flexibility and attention to working conditions. But in the meantime it is sensible to add nurses to the SOL.

However, there is a problem. We were told by DH that employers in England will look to recruit some 11,000 non-EEA nurses over the next 4 years. Once we include nurses for Northern Ireland, Scotland and Wales, the actual figure could be over 14,000, approaching the annual quota of Tier 2 visas (20,700). Clearly, there is a danger that nurses – with their new found priority status – could crowd out skilled migrants from occupations not in shortage, including engineers and workers in the financial sector.

To guard against this, the MAC recommend implementing a safety valve. We suggest an annual ceiling for nurses of 3,000 – 5,000 places in the first year. This might decrease year-on-year in line with the estimated required numbers set out by DH, such that nurses would come off the SOL in 2019 – the point at which DH forecast demand and supply of nurses return to equilibrium.

### **Conclusions: challenges to the health and social care sector**

The MAC recommends placing nurses on the SOL. They are skilled, in shortage and – for a little while – it is sensible to put them on the SOL. But we make this recommendation with considerable reluctance. It seems to us that the shortage is mostly down to factors that could, and should, have been anticipated by DH and related bodies. Further, there seems to be an automatic presumption that non-EEA skilled migration provides the sector with a “Get Out Of Jail, Free” card. I briefly comment on just four areas: workforce planning; training commissions; pay; and who is in charge.

#### Workforce Planning

Until recently, workforce planning took no account of demand for nurses in the care and independent sectors, creating a structural undersupply of nurses in England. Similar issues apply in Scotland, Northern Ireland and Wales. HEE have now begun to factor demand for nurses from the care and independent sectors into their plans.

Equally, the care and independent sectors make minimal effort to ensure that the number of nurses trained is sufficient to meet demand in their sectors. They make little or no direct contribution to the training of pre-registration nurses in the UK and seem content to have a free ride on the back of the government paying for training.

HEE develop their workforce plans by adding together local workforce plans submitted by individual trusts. This means that systemic changes in demand, for example, the drive to better integrate health and social care, are often not adequately reflected in the workforce plans. Additionally, financial pressures in local trusts may lead them to understate their projected workforce needs.

#### Training Commissions

The current shortage of nurses in England is closely linked to the decision to cut training places in England by more than 17% between 2009/10 and 2012/13. We have been told that this was driven more by financial issues than an expectation

that demand would fall. Health Education England have recently confirmed that, even now, the 331 additional places they are funding in 2016/17 falls well below that actually needed – again due to financial constraints.

### Pay

The restraint on nurses' pay instituted by the government was presented to us, and in the evidence to the pay review bodies, as an immutable fact. It is not. It is a choice. There was insufficient curiosity across both the health and care sector about the extent to which pay might be responsible for, and might help alleviate, present recruitment difficulties. By contrast, all parties seemed able to understand how their employees left for higher salaries available through agency work.

Retention issues are a major contributor to current shortages in the NHS - DH should at least explore whether higher pay would improve retention. There is some evidence from the Institute for Fiscal Studies suggesting that nurses' supply of labour to the NHS is sensitive to pay, most notably in London where the shortage appears to be particularly acute.

We have been here before. Our analysis shows that there is a historic pattern of peaks and troughs to the supply of migrant nurses. This pattern offers, at least, highly suggestive indications that migrant nurses have been used to save costs. Nursing is an occupation in which migrants earn, on average, less than UK workers doing the same job. In most other graduate occupations, migrants earn, on average more than UK workers in the same job. It is difficult not to see this as undercutting.

### Who is in charge?

There is a proliferation of bodies overseeing the administration of health and care services. We got evidence from all of them but there was no common theme with a range of views being expressed and data drawn upon. And there is no single, authoritative voice to speak for them. We recognise the efforts of HEE to set up a group to pull together views on workforce planning but the sectors do not help themselves by having a very confusing architecture.

I offer these points to the government in addition to our recommendations re nurses and the SOL. I also wish to state on behalf of the MAC our recognition of the contribution made by migrant nurses to our NHS and care services across the UK and over the years. The MAC is based in a building named after Mary Seacole who was born in Jamaica and served as a nurse during the Crimean War. Non-EEA nurses have a long tradition of making a contribution.

Once again the MAC are indebted to our excellent secretariat. Their administrative and analytical expertise and drafting skills are key ingredients cementing the MAC's reputation.



**Professor Sir David Metcalf CBE**



# The Migration Advisory Committee and Secretariat

The Migration Advisory Committee (MAC) is a non-statutory, non-time limited, non-departmental public body (NDPB) which was established in 2007 and is funded by the Home Office. The MAC is comprised of economists and migration experts who are publicly appointed in line with guidance published by the Office of the Commissioner for Public Appointments; along with ex-officio representatives of the UK Commission for Employment and Skills and the Home Office.

## Chair



Professor Sir David Metcalf CBE from August 2007

## Members



Professor Alan Manning from March 2015



Dr Jennifer Smith from November 2012



Professor Jonathan Wadsworth from December 2007



Professor Jackline Wahba from November 2012

## UK Commission for Employment and Skills representative



Lesley Giles

## Home Office representative



John Thompson

## The secretariat

Cordella Dawson; Ciaran Devlin; Stephen Earl; Emily Fowler; Paul Garner; Tim Harrison; Christopher Haynes; Baljit Khinder; Anna Lacey; Jessica Latchford; Christine Stone; Josephine Thomas.



# Chapter 1: Introduction

## 1.1 About the MAC

- 1.1 The Migration Advisory Committee (MAC) is a non-departmental public body comprised of economists and migration experts that provides transparent, independent and evidence-based advice to the Government on migration issues. The questions we address are determined by the Government.
- 1.2 The MAC has previously been asked to provide advice on a wide range of immigration issues such as the design of the Points Based System (PBS) for managed migration. This includes annual limits, low-skilled migration into the UK and the Tier 1 (Investor) and Tier 1 (Entrepreneur) routes. The MAC is also asked to review occupations and job titles for inclusion on the shortage occupation list (SOL) and has recently completed a wider review of Tier 2.

## 1.2 What we were asked to do

- 1.3 On 15 October 2015, the Home Secretary took the decision to add nurses to the shortage occupation list on an interim basis to ensure that there were safe staffing levels across the National Health Service (NHS) during a time of pressure and changes to expenditure on agency staff.
- 1.4 The Home Secretary then wrote to the MAC commissioning it to examine whether there is a shortage of nurses or specific nursing job titles which it would be sensible to fill through non-European Economic Area (EEA) migration and if they should stay on the SOL.
- 1.5 This commission followed the February 2015 partial review of the SOL where we were asked to review a small number of occupations including graduate occupations within the health sector such as consultant roles, nurses and training grades. At that time, on the basis of our analysis and the evidence we received, we recommended that nurses should not be added to the SOL. This previous MAC consideration is discussed in Chapters 2 and 5.

## Review of nursing

- 1.6 In her October 2015 letter commissioning the MAC, the Home Secretary said:

*“I am conscious that the MAC considered the issue of nursing shortages in the health sector in your partial review of shortage occupations published in February this year and that you recommended against adding nurses to the shortage occupation list, as well as removal of certain specialist nursing roles. I regret asking you to look at this again so soon.*

*“I understand that your recommendation in February was based on the evidence available at the time, including detailed submissions from the Centre for Workforce Intelligence on behalf of the Department for Health and from the Royal College of Nursing and other health sector organisations. However, since then increasing numbers of NHS Trusts and other interested organisations have raised concerns about nurse staffing levels, highlighting recent changes to recommended safe staffing levels within the NHS. In addition, developments since February include the Government’s manifesto pledge to deliver a seven-day NHS and new rules to clamp down on the use of agency staff. I am advised that nursing vacancy rates may be as high as 10% across the health and social care sector, which if so would be twice the maximum level recommended by NICE. It is not for the Home Office to judge these representations and I should therefore be grateful if the MAC could consider the latest evidence.*

*“In view of the potential risks associated with high vacancy rates and the fast-approaching winter period in which we can expect the NHS to be under particular pressure, I have exceptionally agreed to place nurses on the shortage occupation list on a temporary basis pending that full review of the evidence and your subsequent advice.”*

- 1.7 The MAC was asked to submit its report to the Government by 15 February 2016, subsequently extended to the end of February.

### 1.3 What we did

#### MAC Methodology

- 1.8 The MAC’s methodological approach to assess whether an occupation or job title should be placed or retained on the shortage occupation list is set out in detail in our previous reports on the SOL. In brief, we assess against three tests:
- we consider whether individual occupations or job titles are sufficiently **skilled** to be included on the SOL;
  - we also consider whether there is a **shortage** of labour within each skilled occupation or job; and

- finally, we consider whether it is **sensible** for immigrant labour from outside the EEA to be used to fill these shortages.
- 1.9 The requisite skill level for inclusion on the SOL is presently National Qualifications Framework level 6 and above (NQF6+). We most recently identified level NQF6+ occupations in our February 2013 shortage report and found that nurses (standard occupational code (SOC) 2231) were skilled to level NQF6+. We do not repeat that analysis here as nursing remains a graduate entry occupation. Nor did we request evidence from partners on the skill level of nurses. We consider nurses to be skilled to level NQF6+.
- 1.10 This report, therefore, focuses on the shortage and sensible parts of our methodology. We look at whether nurses are in shortage in Chapter 3 and whether it is sensible to fill any shortages with migrant labour from outside the EEA in Chapter 5.

### Call for evidence

- 1.11 We issued a call for evidence on 3 November 2015, which ran until 31 December 2015. We received 59 written submissions of evidence from organisations from around the UK. We also reviewed the evidence we received in preparing our February 2015 report as well as the information we received in response to the publication of this report plus relevant evidence we received during our review of Tier 2 of the Points Based System during 2015. A list of those who supplied evidence in response to the November 2015 call for evidence only, and who have not requested anonymity, is provided in Annex A to this report.

**Table 1.1: Sources of responses to our call for evidence 2015**

	NHS	Non-NHS (care sector)	Non-NHS (other)	All nursing sectors
England	16	11	1	1
Wales	-	1	1	-
Scotland	2	3	-	-
Northern Ireland	-	2	-	1
UK	1	6	6	8

Source: Migration Advisory Committee analysis, 2016

- 1.12 We held 16 separate meetings with various organisations from the healthcare sector. We hosted two open forums in London and held telephone conferences with a number of trusts from around the UK. The Chair of the MAC wrote an article that was published in the Nursing Times informing nurses of the review and inviting them to provide evidence.
- 1.13 In November 2015, we commissioned the Institute for Employment Studies (IES) to conduct research into the labour market for nurses in the UK and its relationship to the demand for, and supply of, foreign-born nurses in the UK. This research will be published separately from this report (see Box 4.2 in Chapter 4 for a summary of the findings).

## Review of nursing

1.14 After the conclusions reached in our 2015 partial review of the SOL, we wanted to improve our evidence base and gain a better understanding of how data is collected across the health service. So we established an informal health and care sector group comprising representatives from sector bodies and staff representatives to meet and discuss how evidence is gathered and is considered.

### 1.4 Structure of the report

1.15 This review is different from our previous reports on the SOL as the focus is on a single occupation only. This has allowed us to approach the exercise in a different way enabling us to go into much greater depth to establish whether or not there is shortage.

1.16 The structure of the report is as follows:

- Chapter 2 provides an overview of the industrial structure in which nurses are employed, and then provides available data relating to the employment of nurses across the UK and the role of non-EEA nurses within this. It then explains recent policy factors that have had an impact on bringing migrant nurses to the UK and looks at previous consideration by the MAC of nurses.
- Chapter 3 looks at whether nurses are in shortage using vacancy data and partner evidence to consider if any shortage is localised or national.
- Chapter 4 looks in detail at the factors affecting the demand for, and the supply of, nurses and then looks at nurse's pay.
- Chapter 5 considers whether it is sensible to retain nurses on the shortage occupation list. It looks at the alternatives to the recruitment of non-EEA nurses and the short and long-term measures to address nursing shortage. We also consider whether conditions should be attached if nurses are retained on the SOL.
- Chapter 6 sets out the MAC's conclusions and recommendations.

### 1.5 Thank you

1.17 We are grateful to all our partners who responded to our call for evidence and to those who engaged with us at meetings and events and those who provided us with data to inform our analysis.

## Chapter 2: Policy and data context

### 2.1 Introduction

- 2.1 This chapter sets some context around the numbers of nurses working across the UK and the role migrant nurses play in contributing to nursing labour supply.
- 2.2 We also set out the institutional context for health and social care generally and for employing and training new nurses. We end the chapter by considering, first, some of the recent policy factors that may have impacted on nursing recruitment and, second, recent MAC work in this area.

### 2.2 The organisation of healthcare across the UK

- 2.3 We begin by providing a high-level overview of the health and care sectors across the UK.
- 2.4 Acute healthcare (i.e. primary care mainly in a hospital setting) is mostly funded (out of general taxation), by means of a ring-fenced budget, and provided, by the public sector.
- 2.5 By contrast social, or secondary, care can be funded either by the public sector (via non ring-fenced local authority budgets) or by the private sector, but is generally delivered by the private sector. This model is broadly followed across England and the three devolved administrations of Scotland, Wales and Northern Ireland, though differences do also exist between them (see below).
- 2.6 As we discuss later, in terms of employment of nurses in the UK, most are employed by the National Health Service (NHS). In this section, therefore, we briefly discuss the arrangements for health and social care between the NHS and the care and independent sectors by examining three broad issues:
- healthcare funding arrangements;
  - the institutional structure; and,
  - the framework for commissioning nurse training.

### Box 2.1: Definitions used in this chapter

**Acute health care:** is health care delivered to a patient requiring active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery.

**Adult nursing:** qualified nurses who provide care for adult patients who are suffering from a variety of health conditions, ranging from minor injuries and ailments, to acute and long-term illnesses and diseases.

**Agency nurse:** a qualified nurse who works indirectly for one or more healthcare employer (e.g. in a nursing home or NHS hospital) via an employment agency.

**Band 5 nurse:** the starting grade under the Agenda for Change system for a newly qualified nurse. For qualified nurses, Agenda for Change bandings range from Bands 5 to 9. The majority of migrant nurses recruited from outside of the EEA are brought in at Band 5.

**Bank nurse:** a qualified nurse who works directly for the healthcare employer as part of a nurse bank. A nurse bank is a resource of nurses who can be temporarily assigned to roles across a NHS trust to plug gaps in the supply of permanent nursing staff or to bring in specific skills. Some permanent nursing staff also take on additional bank nurse roles in order to earn extra money.

**Care and Independent sector:** As well as providing acute care services, this sector provides long-term care for people who may not be able to live independently. Employers can be divided into three main groups:

- **For profit** – single owners and large corporations that own single and groups of acute hospitals or nursing homes.
- **Not for profit/registered charities** – can be national organisations, single owners or smaller set ups, the majority of which offer care home facilities for older people, those with learning disabilities or those with mental health needs. A number of organisations offer care provided by qualified nurses.
- **Voluntary** – organisations which provide care homes from charitable donations.

**Children's nursing:** qualified nurses who work with children of all ages suffering from many different conditions.

**Learning disabilities nursing:** qualified nurses who provide support to people with learning disabilities, and their families, carers and friends.

**Mental health nursing:** qualified nurses who work with people suffering from various mental health conditions, and their family and carers, to offer help and support in dealing with the condition.

**NHS sector:** the publicly funded healthcare system for the UK which provides healthcare to every legal resident with most services free at the point of use. At grass-roots level the NHS is grouped into the following areas:

- **Primary care** – the care given to people when they first become aware of a health problem.
- **Secondary care and emergency care** – the care that is provided to people in an emergency or following a referral from a primary care organisation.
- **Tertiary care** – refers to specialist care such as renal transplant or cardiac surgery. Tertiary care is usually accessed as a referral from secondary care.

### (i) Healthcare funding

#### *NHS*

- 2.7 Public healthcare has a devolved matter in Scotland, Wales and Northern Ireland since 1999, though public funding allocations for the devolved administrations is still determined by HM Treasury.
- 2.8 Once HM Treasury budgets have been decided, the devolved administrations have the freedom to allocate their funds as they believe appropriate. In the financial year 2013-14 total expenditure on public sector healthcare across the UK amounted to around £129 billion, or about £2,000 per head of population. Of this, England's expenditure was £107.4bn, Scotland £11.5bn, Wales £6.1bn and Northern Ireland £3.9bn (HMT, 2015).
- 2.9 In 2014-15 the departmental expenditure limit (DEL) for NHS England was £113 billion. The National Audit Office (NAO, 2016) estimate that £43 billion (38 per cent) was spent on clinical staffing costs. Nurses make up 38 per cent of clinical staff in the NHS, and their total pay amounted to £11 billion, or 9.7 per cent of the total NHS budget (NHS Hospital and Community Health Service, 2015). Note that this is the figure for total earnings, which will be less than the total cost to employers.
- 2.10 The public health sector has been facing financial pressures in recent years. Since 2010, overall NHS funding has increased by just under 1 per cent each year in real terms, compared to 3.7 per cent a year since the NHS was created in 1948 (The King's Fund, 2016).
- 2.11 Two-thirds of the 240-plus NHS trusts in England are expecting to be in financial deficit by the end of the current financial year, resulting in an expected aggregate overspend of £2.3bn (The King's Fund, 2016).

#### *Care and independent sectors*

- 2.12 The UK independent health and care sector is estimated to have generated revenues of more than £45bn in 2015 (LaingBuisson, 2016). This included £17.1bn from care homes, £6.6bn for homecare, £7.8bn for private acute medical care and £1.3bn for mental health hospitals.
- 2.13 Further analysis carried out by LaingBuisson (LaingBuisson, 2015) estimated the market value of residential care for older people at £15.9bn of which only £1.6bn was from local authority provision. In addition to this, the homecare and community care sector was valued at £8.1bn, and funded mostly by the public sector (£4.2bn spent by local authorities and £2.6bn spent by the NHS).

### (ii) Institutional structure

#### *NHS*

- 2.14 We have drawn on information from NHS England (NHS England, 2015) and Bevan et al. (Bevan et al., 2014) to describe the arrangements for publicly provided health and social care across the UK:

## Review of nursing

- The Health and Social Care Act that came into force in April 2013 radically changed the way the NHS is organised in **England**. The Department of Health retains overall accountability for securing value for money for spending on health services, including on training and employing clinical staff. Delivery of health services is based on a market-based purchaser-provider model. Most (£96bn) of the £107bn Department of Health budget in 2013-14 was allocated to NHS England and two-thirds of this (£64bn) was allocated to 211 GP-led clinical commissioning groups (CCGs) and local authorities who commission health services for their populations. Healthcare services are then delivered by some 240 NHS trusts and foundation trusts. NHS England can also commission some specialised services directly.
  - NHS **Scotland** consists of 14 regional NHS Boards, which are responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services. The purchaser-provider model in Scotland was abolished in 2004 and NHS boards now plan, commission and deliver NHS services for their respective areas.
  - NHS **Wales** delivers services through three NHS trusts and seven Local Health Boards, which secure the delivery of services in their areas. As is the case in Scotland, Local Health Boards plan, secure and deliver healthcare services for their populations. Wales abolished the purchaser-provider model in 2009.
  - In **Northern Ireland**, the Health and Social Care Board are ultimately responsible for commissioning both health and social care through five Local Commissioning Groups. Provision of integrated health and social care is the responsibility of five Health and Social Care Trusts.
- 2.15 To date only Northern Ireland has a fully integrated health and social care service, though this remains an objective across the rest of the UK.

### *Care and independent sectors*

- 2.16 Skills for Care (Skills for Care, 2015a) estimate that in 2014 there were 18,000 organisations running 39,500 establishments which were involved in providing or organising adult social care in England. The Care Quality Commission is responsible for regulating over 17,000 of these, including 4,600 care homes with nursing and 12,700 care only homes.
- 2.17 Care Inspectorate, the official body responsible for inspecting the standards of care in Scotland, are responsible for regulating approximately 14,000 care services across Scotland.

### **(iii) Responsibility for nurse training**

#### *NHS*

- 2.18 Training places for nurses are mostly centrally commissioned: Health Education England, NHS Education for Scotland, Department of Health –

Social Services and Public Safety and the Welsh Government set the number of training places for England, Scotland, Northern Ireland and Wales respectively. Despite our best efforts, it has been difficult to find precise numbers of training commissions across the UK. In 2014-15 there were approximately 24,000 new nurse training commissions across the UK: 19,200 in England; 3,200 in Scotland; 1,100 in Wales and 700 in Northern Ireland (Higher Education England, 2015; NHS Scotland, 2015; Royal College Nursing, 2015a).

- 2.19 Health Education England (HEE) is responsible for workforce planning, education and training in England. HEE works with 13 Local Education and Training Boards (LETBs) to develop national and regional workforce plans and commissions the training of new clinical staff. NHS trusts submit local workforce plans to their local LETBs. This process from workforce planning to producing newly qualified nurses can take up to five years (including three years of the degree course itself).
- 2.20 Furthermore, workforce plan coverage is incomplete as information is generally not gathered from general practices, local authorities or private or third-sector providers (NAO, 2015).
- 2.21 Because there is an annual ceiling on publicly commissioned training places (due to a number of factors including forecast need from trusts but also available public funding), some NHS trusts may also privately commission training places over and above this. In these cases student nurses will be expected to pay tuition fees themselves instead of receiving a bursary that is available for centrally commissioned training.
- 2.22 To get a sense, therefore of, the overall supply of nurses in pre-registration training, it is instructive to consider data from the Higher Education Statistics Agency (HESA). HESA provides information on enrolments for nursing degrees. In 2014-15, there were 27,050 full-time and 5,540 part-time first year nursing degree students across the UK as a whole (HESA, 2015).

### *Care and independent sectors*

- 2.23 Comparing these two data sources suggests that the majority of new nursing students are as a result of publicly funded central commissions. It also appears that the care and independent sectors have little or no direct responsibility for the costs of initial nurse training, even though ultimately they are employers of nurses. Furthermore, until HEE was established in 2012, little account was taken by central workforce planning for the volumes of nurses that would end up moving to the non-NHS healthcare sector.

## **2.3 The nursing workforce in the UK**

### *Defining nurses*

- 2.24 A nurse is a healthcare professional who is focused on caring for individuals, families, and communities. They are capable of assessing, planning, implementing, and evaluating care independently of doctors.

## Review of nursing

- 2.25 Nurses work in hospitals (public or private), and more widely in GP surgeries, schools, care and nursing homes. In the NHS, nursing roles at Band 5 or above require a bachelor's degree from a higher education university or college.
- 2.26 The Nursing and Midwifery Council (NMC), the professional regulatory body for nurses and midwives in the UK, is responsible for the registration of all nurses across the UK and recognises four fields of practice for registered nurses:
- Adult nursing
  - Mental health nursing
  - Learning disabilities nursing
  - Children's nursing
- 2.27 Within each of these fields of practice there are a number of different specialties, some of which we have previously recommended for inclusion on the shortage occupation list, for example, specialist nurses who work in neonatal or paediatric intensive care units.

### *Nursing employment across the UK*

- 2.28 Arriving at a robust estimate of the number of nurses working in the UK is not straightforward. Generally there are good data on the numbers working within the NHS in each of England, Scotland, Wales and Northern Ireland, though there can be differences based on the types of nurse included or indeed wider aggregations that include midwives and health visitors.
- 2.29 Beyond this the data for numbers working in the care sector is patchier and for those working in other parts of the private healthcare sector patchier still.
- 2.30 We have endeavoured therefore to arrive at our best estimate that we will use throughout this report (see Table 2.1 below).

Source		UK	England	Wales	Scotland	Northern Ireland
<b>Labour Force Survey</b>	<b>Nurses in employment</b>	630,000	503,000	39,000	64,000	25,000
	<i>Of which:</i>					
	<b>NHS</b>	502,000	400,000	34,000	49,000	19,000
	<b>Non-NHS</b>	128,000	103,000	-	15,000	-
<b>NMC</b>	<b>Registered nurses</b>	655,000	447,000	28,000	68,000	21,000
<b>NHS</b>	<b>NHS workforce</b>	471,000	361,000	25,000	68,000	17,000

Source: Labour Force Survey (2015), Nursing and Midwifery Council (2015), Health and Social Care Information Centre (2015), Stats Wales (2014), Information Services Division Scotland (2015), Health and Social Care Northern Ireland (2015).

Notes: \* All estimates are for 2015 except the NHS figure for Wales which is for 2014 (the latest available year). LFS estimates based on individuals employed SOC code 2231 (nurses), 4 quarter average October 2014 - September 2015. (-) indicates an estimate lower than 10,000 which is not published due to small sample sizes. NMC data excludes registrations for midwives. Registrations for the following categories are included: nurse; nurse & specialist community public health nursing (SCPHN); nurse and midwife; nurse, midwife & SCPHN. The UK total is larger than the sum of the individual regions as the regional figures do not include those who registered overseas. NHS workforce statistics include figures for both nurses and midwives. Regional figures may not sum to match the UK total due to rounding.

- 2.31 Comparing survey data from the Office for National Statistics' (ONS) Labour Force Survey and nurse registration data from the NMC suggests that there are currently around 650,000 nurses in the UK. Of these, up to 500,000 work in the NHS.
- 2.32 This would imply that up to 150,000 nurses are therefore working outside of the NHS. Exact numbers are difficult to corroborate, but evidence from Skills for Care estimates that in 2014 there were 49,500 registered nurse jobs in the adult social care sector in England (Skills for Care, 2015a). It has been estimated that there are a further 30,000 to 50,000 registered nurses in the private and independent sector in England (HEE, 2015).
- 2.33 The Care Inspectorate in Scotland provided us with data from the Scottish Social Service Sector report on 2014 workforce data estimating that there were 6,850 nurses working in the social care sector in Scotland.

#### *The contribution of foreign nurses*

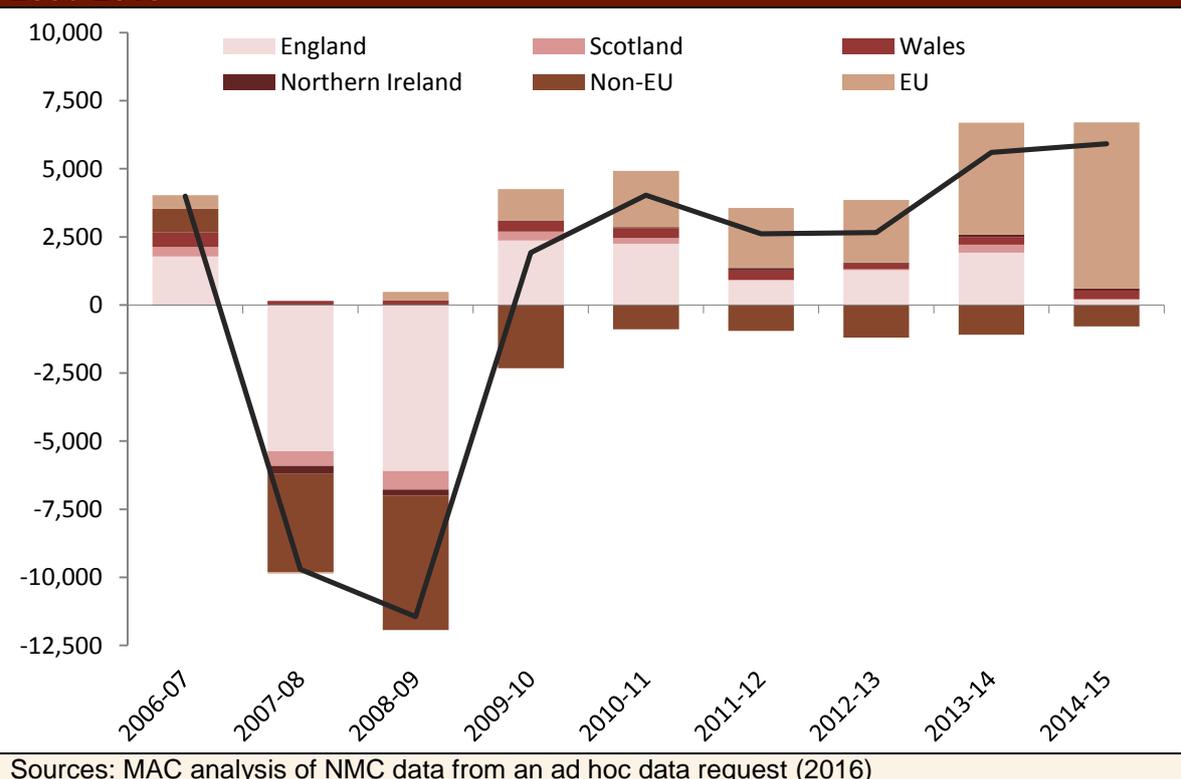
- 2.34 According to NMC data on registered nurses and midwives for the UK as a whole, 69 per cent were from England (as measured by the country of initial registration). A further 17 per cent were from the rest of the UK. One in ten was initially registered outside of the EU and 4 per cent registered within.
- 2.35 Over the past decade there has been a marked shift in the origin of registered nurses in the UK. Overall the number of registered nurses and midwives has increased by around 5,600 since 2005-06. However, this masks the fact that between 2006-07 and 2008-09 numbers fell by over 21,000, mainly among

## Review of nursing

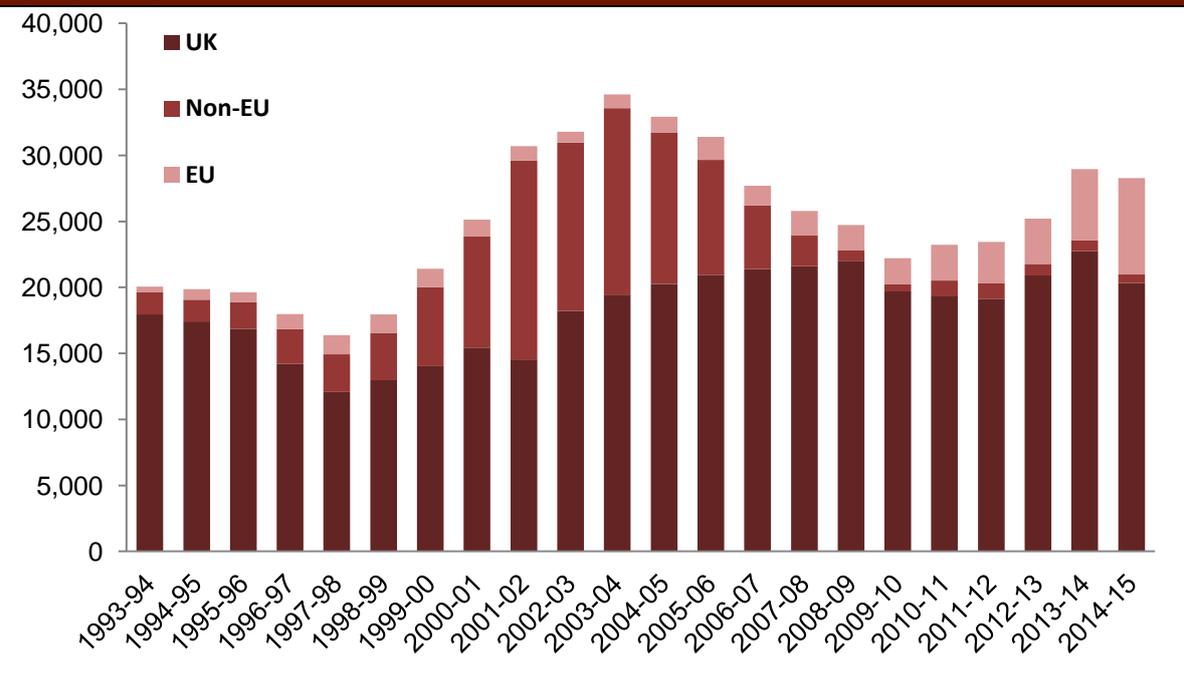
those initially registered in England (a decline of around 11,500), in Scotland (1,200) and from outside the EU (8,500).

- 2.36 Numbers have since increased again by 22,700, but this has been mainly driven by an increase of almost 18,000 from nurses and midwives initially registered in the EU. Registrations from the UK have risen again by 12,000, but there has been a continued decline of 7,200 among those initially registered outside the EU (Figure 2.3).

**Figure 2.1: Annual change in UK registered nursing and midwifery stock, 2006-2015**



- 2.37 Changes in stocks of registered nurses over time will reflect the degree of flows onto and off the NMC register. In terms of outflows we consider the case in Chapter 4 of those leaving the UK to work as nurses or midwives overseas.
- 2.38 For inflows, Figure 2.2 demonstrates the volume of nurses and midwives joining the NMC register from both the UK and abroad. Currently there are around 29,000 new registrations a year, but the inflow has varied significantly over the past two decades, from a low of 16,000 in 1997-98 to almost 35,000 (of which 15,000 were non-UK) in 2003-04.

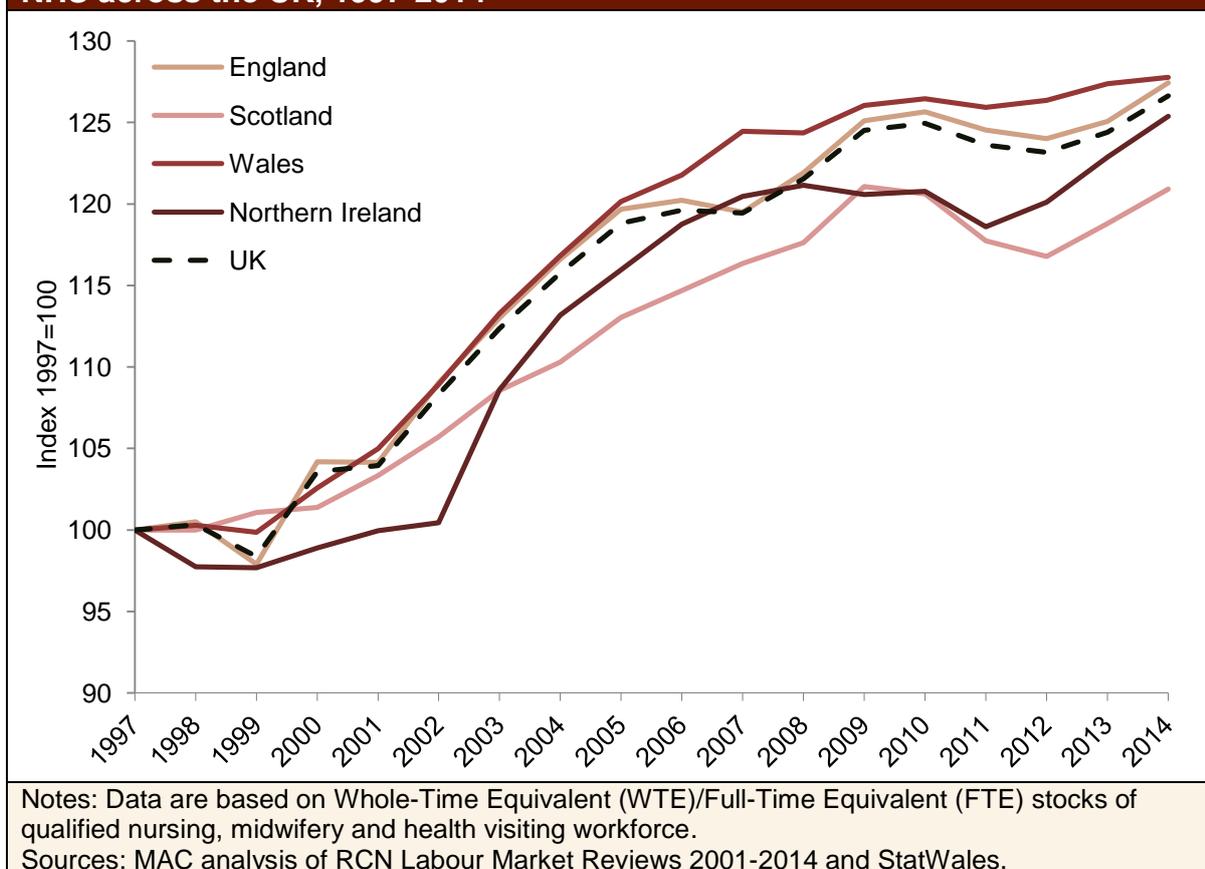
**Figure 2.2: Initial registrations of qualified nurses by source region, 1993-94 to 2014-15**

Source: MAC analysis of NMC Initial Registrations, ad hoc data request; OECD International Migration Outlook 2015

## 2.4 NHS nurse volumes in the UK

- 2.39 Within the NHS, the largest employer of nurses in the UK, the above trends from the NMC data are largely borne out by the trend in total employment of qualified nurses and midwives (Figure 2.3).
- 2.40 That is, nurse volumes (measured in full-time equivalent terms) were either flat or declined across the UK in the late 1990s, rose significantly in the early 2000s (from 305,000 to 371,000), before slowing again in 2006-07. In 2008 and 2009, the total number of qualified nurses and midwives rose by almost 16,000, before falling sharply by 5,500 between 2010 and 2012. By 2014 volumes had once again recovered by 10,800 such that the overall volume of qualified nurses and midwives in the NHS across the UK stood at 393,000,

**Figure 2.3: Trends in qualified nurses and midwives employed (WTE) in the NHS across the UK, 1997-2014**



- 2.41 This 'boom and bust' cycle has been the subject of various enquiries by the House of Commons Health Committee in 1999, 2006-07 and 2012-13. Key to all of this has been concern about the role of workforce planning in the NHS.
- 2.42 A House of Commons Health Committee report in 2006-07 stated (House of Commons, 2007):

*"The health service has changed dramatically in recent years, most notably through the major increase in staff numbers which took place between 1999 and 2005. Rapid workforce expansion was a necessary response to the "crisis" in staffing numbers described in the Committee's 1999 report. However, the rate of growth considerably exceeded expectations, and far outstripped the targets set in the NHS Plan. Given the increase in funding levels, such a high level of growth was inevitable. Many new staff were recruited from overseas because of limited availability of UK staff. Eventually many organisations recruited more staff than they could afford to pay. This was a major cause of the widespread deficits which emerged across the NHS from 2004-05 onwards."*

2.43 The Committee also noted that:

*“The emergence of deficits after 2005 triggered the start of a bust phase with widespread job reductions, sweeping education and training cuts and severe pay restrictions... workforce changes have tended to respond to prevailing financial trends, and the workforce reform agenda, articulated by A Health Service for all the Talents<sup>1</sup>, has too often been overlooked. The expansion of the workforce was reckless and uncontrolled and increases in funding were often seen as a blank cheque for recruiting new staff. Such problems raise serious questions about the effectiveness of the current workforce planning system.”*

2.44 In Chapter 4 we consider the factors affecting the demand for, and the supply of, nurses at the current time, including the pipeline of new student nurses (both publicly and privately funded) and financing pressures. However, there do appear to be similar factors now affecting nursing levels as there were a decade or so ago, which are leading to mismatches between supply and demand and to increasing recruitment of overseas nurses. Recent estimates suggest there is currently a shortfall of 15,000 nurses in the NHS in England alone (NHS Improvement, 2016). This equates to about 5 per cent of the current qualified NHS nursing stock in England in full/whole time equivalent terms.

2.45 But the UK is by no means alone. It has been recognised that there has, for a number of years now, been a global shortage of healthcare workers. In the UK, as in other OECD countries, the healthcare sector is characterised by a relatively high share of foreign-born workforce. According to a recent study, 14.5 per cent of practising nurses across the OECD in 2010-11 were foreign-born, up from 11 per cent a decade earlier (OECD, 2015b).

2.46 For the UK the share was higher at 21.7 per cent (up from 15.2 per cent in 2001). Using nurse registration data from the UK, the OECD calculated that almost two-thirds of the overall increase in nurses over the decade was foreign-born. This was on a par with other countries such as Australia and Ireland, but actually less than in Belgium, Denmark and New Zealand. So, the UK experience of increasing recruitment of foreign-born nurses is not unique by any means, though it is interesting to note that the OECD found that of 29 OECD countries surveyed only the UK and Ireland had actually decreased their new nurse training intake over the period 2007 to 2012.

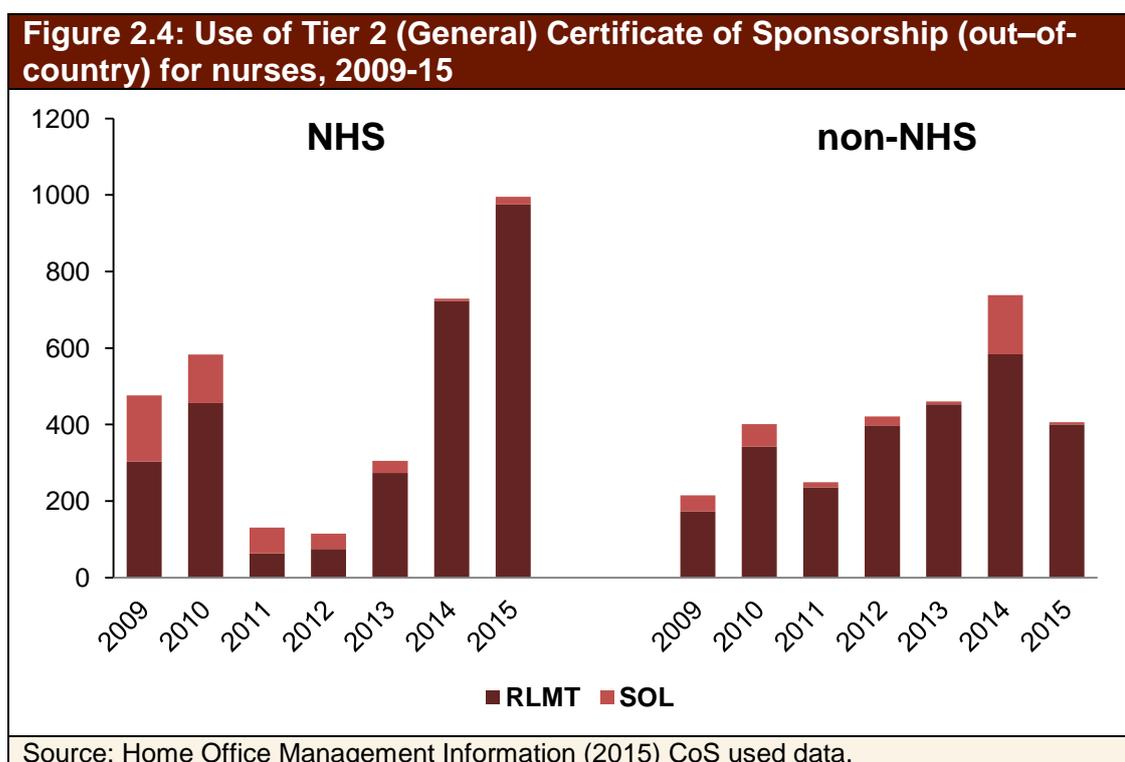
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<sup>1</sup> A Health Service of all the talents was a consultation document on the review of workforce planning published by the Department of Health in April 2000. The document made a number of proposals and recommendations covering four key areas of greater integration and more flexibility; better management ownership, clearer roles and responsibilities; improved training, education and regulation; and staff numbers and career pathways. On staff numbers and career pathways, the document recommended, amongst other things, a review of the longer-term requirements for all professional staff and proposed changes to the contracts of consultants, the career structure of non-consultant staff and a fundamental review of the primary care workforce. A copy of the document is here [http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4007967](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007967)

## Review of nursing

### (i) Recent non-EEA nurse immigration

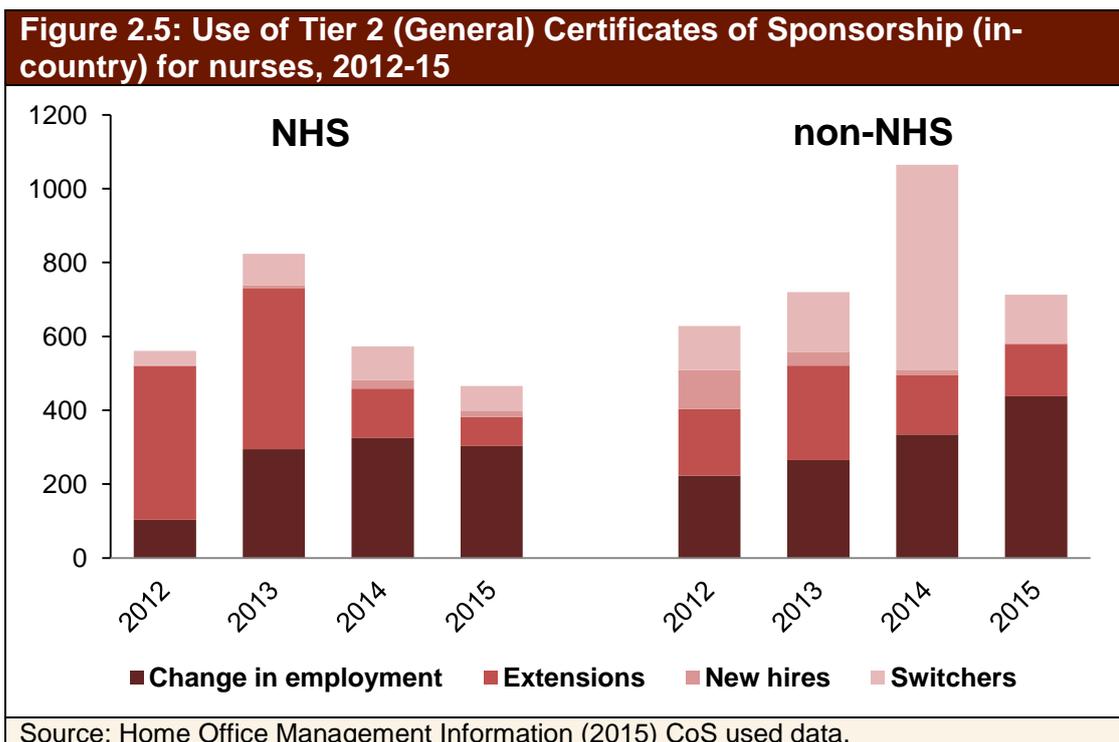
- 2.47 The channel through which skilled workers, including nurses, can come to the UK from the outside the EEA is Tier 2 of the immigration system. The Tier 2 (General) route is intended for those skilled economic migrants who are looking to settle in the UK and is capped at 20,700 places a year. Tier 2 (General) is comprised of two parts: the Shortage Occupation List (SOL) and the Resident Labour Market Test (RLMT).
- 2.48 We present data below of the volume of Tier 2 Certificates of Sponsorship (CoS) used by healthcare employers, separating out NHS from non-NHS employers (Figure 2.4). We consider first out-of-country flows, which are subject to the 20,700 annual limit.



- 2.49 The volume of Certificates of Sponsorship (CoS) used to bring non-EEA nurses into the UK has risen markedly since 2011. In the case of NHS employers, volumes have increased almost ninefold in the space of five years, albeit from a trough in 2012. Non-NHS employer demand for CoS more than doubled to almost 600 between 2011 and 2014, before falling back to around 400 in 2015. Across both sectors there were around 1,400 CoS used in total for nurses in 2015.
- 2.50 CoS usage, especially in the NHS, prior to 2011 (when the cap was introduced) was also relatively high (almost 600 in 2010). What is noticeable is the declining proportion of CoS that were used through the SOL. Again, among NHS employers, over a third of CoS used were under SOL in 2009. By 2015, this had fallen to less than 2 per cent. Healthcare employers were therefore free to recruit non-EEA nurses via RLMT, which, unlike SOL, requires the job to be advertised nationally for four weeks first. Moreover,

there was comparatively little use made by NHS employers of Tier 2 (General) to bring non-EEA nurses into the UK in 2011 and 2012.

- 2.51 Healthcare employers can also recruit non-EEA nurses within the UK (so called in-country), which is not subject to the 20,700 limit. In-country nurse hiring shows a different pattern to out-of-country recruitment. For NHS employers in-country recruitment is lower and has been declining since 2013 (Figure 2.5). In fact, these additions to nursing supply are less than they first appear: the majority of ‘new’ nurses are either extending their current visas or changing employers within the Tier 2 route (most likely from other healthcare employers).



- 2.52 For non-NHS employers, the scale of in-country recruitment is higher – almost an extra 1,800 nurses in 2014 and 2015 combined. Once again, extensions or changing Tier 2 employers are a major reason for this. However, non-NHS employers have also sourced more nurses among those switching immigration category, especially from the Tier 4 student route. In 2014, over half of their in-country recruitment of non-EEA nurses was via this channel.

**(ii) Where are new non-EEA nurses employed?**

- 2.53 There also appears to be quite an uneven usage of CoS for nurses, both geographically and across employers (Tables 2.2 and 2.3 below). In the NHS, the vast majority are hired by employers in England (at least 98 per cent of the total in the last two years). Moreover, London and the South East accounted for around two-thirds or more of all nurses CoS used since 2013, which is proportionately well above its share of total UK employment (25 per cent).

**Table 2.2: Usage of Certificates of Sponsorship (out-of-country) for nurses working in the NHS, 2009 to 2015**

	2009	2010	2011	2012	2013	2014	2015
<b>Total CoS used</b>	<b>476</b>	<b>583</b>	<b>131</b>	<b>115</b>	<b>305</b>	<b>729</b>	<b>995</b>
<i>% used in England</i>	94	95	99	83	92	98	98
<i>% used in London &amp; South East</i>	33	49	80	57	68	84	63
<b>No. of Organisations using CoS</b>	<b>71</b>	<b>57</b>	<b>20</b>	<b>36</b>	<b>30</b>	<b>43</b>	<b>61</b>
<i>Ave CoS by Org.</i>	7	10	7	3	10	17	16
<b>CoS used by top 5 Organisations.</b>	<b>287</b>	<b>352</b>	<b>114</b>	<b>59</b>	<b>240</b>	<b>535</b>	<b>397</b>
<i>As % total used CoS</i>	60	60	87	51	79	73	40
<b>Highest user</b>	<b>147</b>	<b>134</b>	<b>44</b>	<b>21</b>	<b>95</b>	<b>195</b>	<b>169</b>
<i>As % total used CoS</i>	31	23	34	18	31	27	17

Source: Home Office Management Information CoS used (year ending December 2015)

- 2.54 It is also the case that only a minority of NHS employers resort to hiring nurses from outside of the EEA. Some 61 NHS trusts or other bodies hired from outside Europe in 2015, though the number has been rising since 2011 when only 20 trusts did so. Given that there are around 240 NHS trusts in England alone this means that just over 25 per cent of NHS organisations are using this channel for recruitment in any one year.
- 2.55 This recent rise in the number of organisations recruiting abroad has also coincided with a higher average intake (16 per organisation in 2015 versus only three in 2012). However, a small number of employers tend to dominate overall recruitment: in 2013 and 2014 just five NHS trusts and bodies accounted for around three-quarters of all used CoS for nurses in the NHS. In both 2014 and 2015 one trust has used in excess of 160 CoS each year, about a fifth of the overall NHS nurse total.
- 2.56 If there is indeed a shortage of nurses across the UK, then this analysis highlights that the degree to which NHS employers resort to non-EEA nurse recruitment varies considerably. To explore this further, we have commissioned, in parallel with this report, some external research looking into the factors driving this (see Chapter 4 for more information).

**Table 2.3: Usage of Certificates of Sponsorship (out-of-country) for nurses not working in the NHS, 2009 to 2015**

	2009	2010	2011	2012	2013	2014	2015
<b>Total CoS used</b>	<b>217</b>	<b>401</b>	<b>249</b>	<b>421</b>	<b>461</b>	<b>590</b>	<b>407</b>
<i>% used in England</i>	74	89	89	85	82	85	83
<i>% used in London &amp; South East</i>	40	62	62	47	47	43	57
<b>No. of Organisations using CoS</b>	<b>97</b>	<b>102</b>	<b>79</b>	<b>140</b>	<b>145</b>	<b>145</b>	<b>98</b>
<i>Ave CoS by Org.</i>	2	4	3	3	3	4	4
<b>CoS used by top 5 Organisations.</b>	<b>74</b>	<b>177</b>	<b>93</b>	<b>121</b>	<b>120</b>	<b>198</b>	<b>230</b>
<i>As % total used CoS</i>	34	44	37	29	26	34	57
<b>Highest user</b>	<b>32</b>	<b>55</b>	<b>43</b>	<b>58</b>	<b>50</b>	<b>101</b>	<b>149</b>
<i>As % total used CoS</i>	15	14	17	14	11	17	37

Source: Home Office Management Information CoS used (year ending December 2015)

2.57 In the non-NHS sector, although CoS are still mostly used in England, this proportion is lower than for the NHS sector. The same is broadly true of CoS used in London. There are more organisations making use of CoS each year, but with lower average use per organisation. Although again there are some principal users who account for a significant minority of CoS used, the degree of concentration appears to much less than in the NHS sector. The exception to this was in 2015 when the top five users accounted for over half of all CoS used in the non-NHS sector, but this was driven in large part by a single employer alone using 37 per cent of all CoS for nurses.

### **(iii) Nationality of non-EEA nurses**

2.58 The majority of non-EEA nurses recruited by the health sector in recent years have come from India and the Philippines (almost three-quarters of the total since 2009). It is noticeable that most of the top ten nationalities are from countries where English is either the national language or is widely spoken.

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**Table 2.4: Breakdown of Tier 2 used Certificates of Sponsorship (in-country and out-of-country) for nurses by nationality, 2009 to 2015**

Nationality	2009	2010	2011	2012	2013	2014	2015	Total	% of total
India	975	740	422	763	913	1343	982	6,138	37%
Philippines	655	762	310	542	1072	1231	1118	5,690	34%
Nigeria	176	114	41	68	67	44	68	578	3%
Nepal	60	35	19	36	25	92	52	319	2%
Australia	60	52	31	52	39	33	40	307	2%
Croatia	1	0	0	1	0	9	137	148	1%
Zimbabwe	517	257	56	57	36	21	14	958	6%
USA	24	43	33	25	24	18	30	197	1%
South Africa	120	110	19	25	18	23	24	339	2%
Jamaica	59	30	11	12	2	7	16	137	1%
<b>Total top 10</b>								<b>14,811</b>	<b>90%</b>
<b>Total</b>								<b>16,535</b>	

Source: Home Office Management Information CoS used (year ending Dec 2015)

### 2.5 Recent policy factors impacting on nurse recruitment

2.59 In this section we highlight a number of policy-related factors that may have impacted, or are likely to impact, on recent efforts to recruit more nurses. We therefore cover in turn:

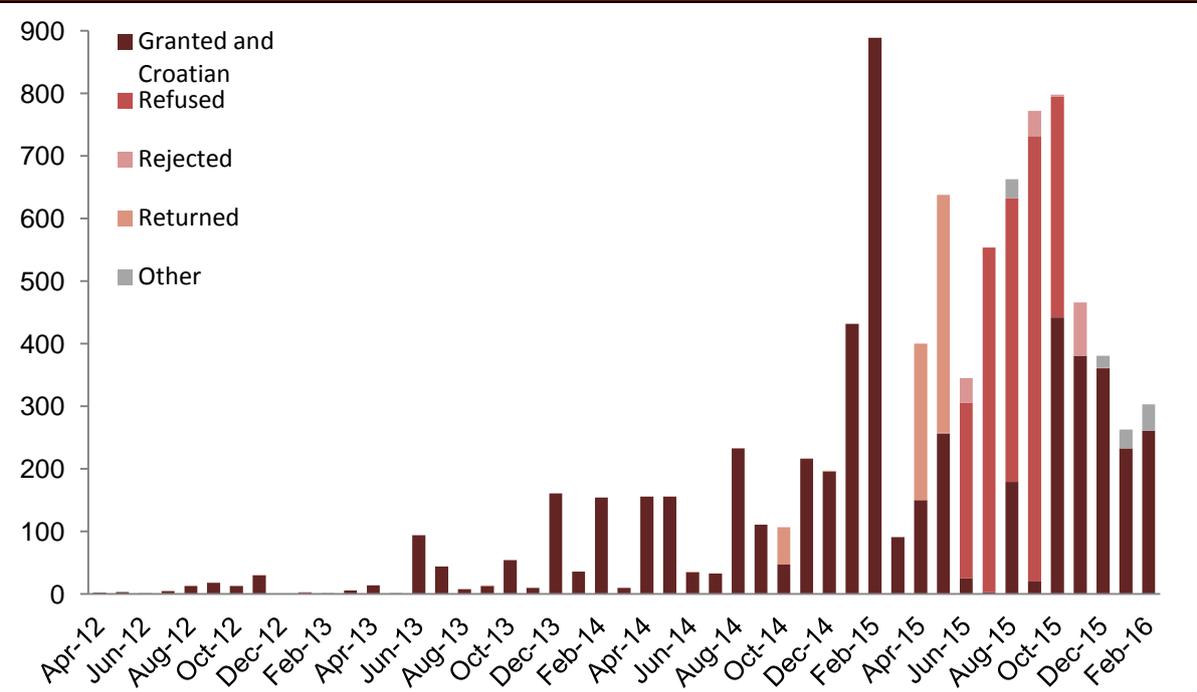
- The Tier 2 (General) limit being hit in mid- to late 2015;
- Restrictions on the amount NHS trusts could spend on agency nurses;
- The addition of nurses to the Shortage Occupation List (SOL); and
- The health sector funding and policy changes announced in the 2015 Autumn Statement.

#### (i) Reaching the Tier 2 limit in 2015

2.60 We set out above that the Government has had in place an overall annual limit of 20,700 places under the Tier 2 (General) route since 2011 (places are allocated on a month-by-month basis). For most of the period since 2011, volumes of all non-EEA skilled workers coming to the UK have been well below this level.

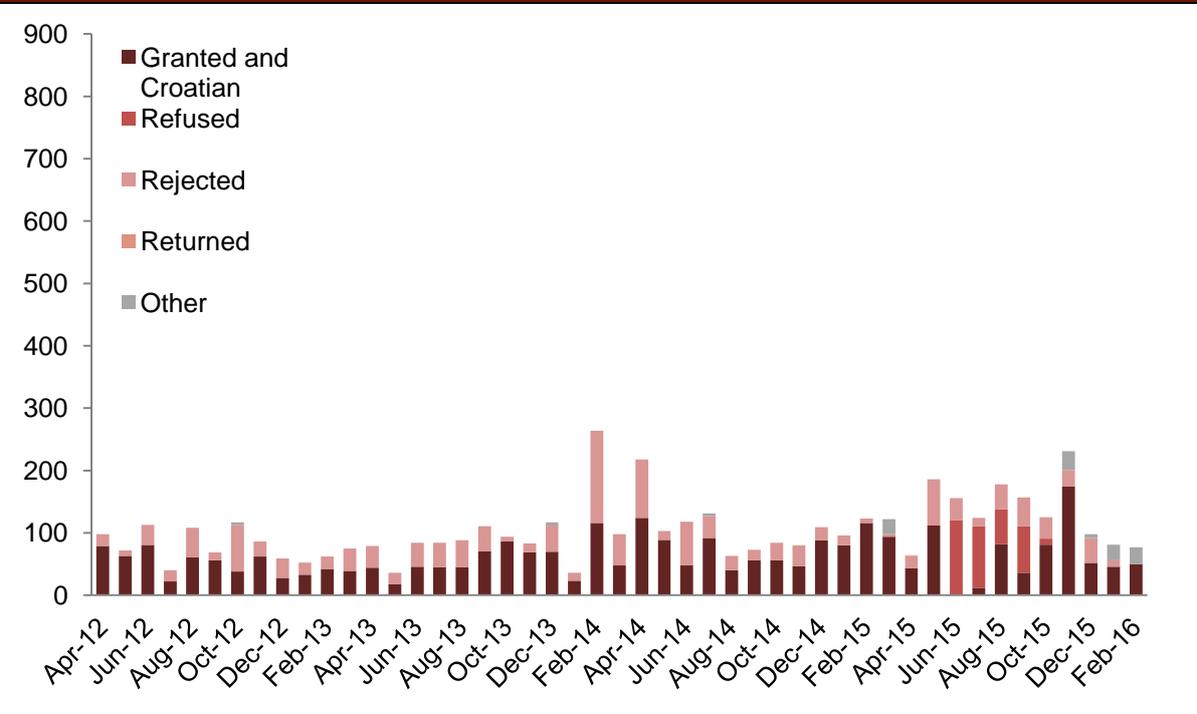
2.61 However, in June 2015 the monthly allocation was over-subscribed for the first time, resulting in lower-paying occupations having their applications for the Restricted Certificates of Sponsorship (RCoS) refused.

**Figure 2.6a: RCoS volume of applications by decision, NHS, April 2012 - Feb 2016**



Source: Home Office Management Information (2016) Monthly RCoS data.

**Figure 2.6b: RCoS volume of applications by decision, non-NHS, April 2012 - Feb 2016**



Source: Home Office Management Information (2016) Monthly RCoS data.

2.62 Nursing was the occupation most severely affected by the monthly limit being reached, with over 2,700 nursing applications refused as a result. Between

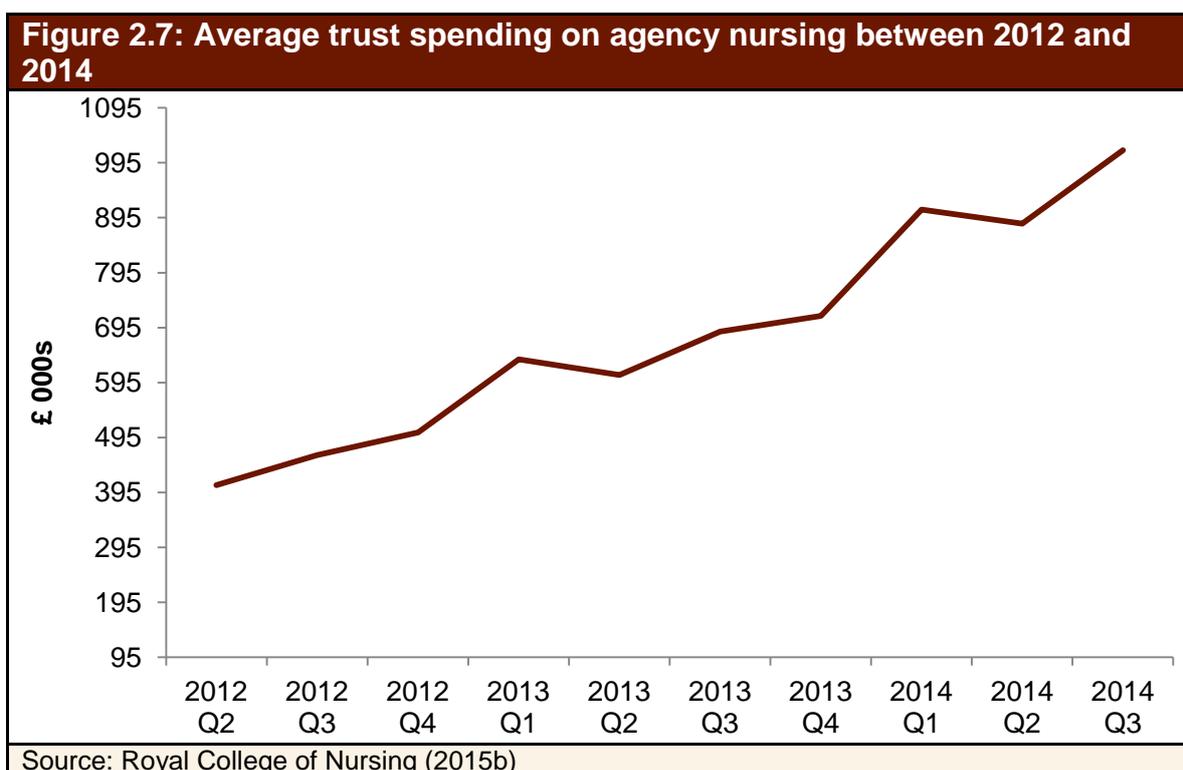
## Review of nursing

April 2015 and February 2016 there have been 7,200 RCoS applications for nurses.

- 2.63 Four out of five applications are currently from NHS trusts, compared to only one in ten three years ago. What is clear from Figure 2.6 is the growth in applications for NHS trusts over time, especially in 2015, compared with the non-NHS sector, which has remained broadly constant (it should be noted that these data may include some double-counting as employer sponsors can re-submit applications that were refused in earlier months).
- 2.64 In Chapter 5, we discuss how the Tier 2 limit will determine the importance of the shortage occupation list if it binds again in the near future.

### (ii) Expenditure cap on agency staff

- 2.65 The Royal College of Nursing (RCN) have published data on agency spending, gathered from 168 trusts. Between July-September 2012 and July-September 2014, average agency spending per trust has increased by 120 per cent (RCN, 2015b) (Figure 2.7).



- 2.66 Employers within the health sector use bank and agency staff as a way to fill gaps in staffing and to ensure that services continue to be delivered. The NAO (NAO 2015) has estimated that spending on agency staff overall (i.e. not just nurses) in the NHS in England increased from £2.2bn in 2009-10 to £3.3bn in 2014-15. Based on evidence from the RCN, we estimate spending on agency nurses is around £1bn a year, or 1 per cent of overall NHS expenditure in England (RCN, 2015b).

- 2.67 In addition to this, spending on bank nurses increased from £0.7bn to £1.4bn over the same period. The NAO estimated that on average the hourly rate for bank nurses was £27, and £39 for agency nurses. This compares with a basic rate (excluding unsocial hours) of around £11 an hour for a qualified nurse at the starting point at Band 5 of the Agenda for Change pay scale. According to NAO estimates, the total hours of agency and bank nurse time would equate to 30,000 full-time equivalent nurses across all trusts in 2014-15.
- 2.68 In order to contain agency costs, Monitor and the NHS Trust Development Authority introduced a series of restrictions on agency staff usage in autumn 2015. This included, in November 2015, a cap on the amount of money that trusts can pay per hour for agency staff working for the NHS. The intention was to help NHS providers to reduce their wage bills, encourage workers back into substantive and bank roles and to ease the financial pressure facing the NHS. Also, an annual ceiling on the amount individual NHS trusts and NHS foundation trusts can spend on agency nursing staff has been set and trusts must also procure agency nursing staff via approved framework agreements.

### **(iii) Inclusion of nurses on SOL from October 2015**

- 2.69 In October 2015, the Government decided (outside of the usual MAC determination process) to add all degree-level nurses (SOC 2231) to the SOL. This is the first time in almost a decade that all non-EEA nurses have had prioritised access to the UK labour market. In 2006, the Government had removed Band 5 and Band 6 nurses from the SOL when it operated under the work permit system at the time.
- 2.70 It is difficult to assess properly what impact on non-EEA nurse inflows their addition to the SOL has had since October 2015. Not only is this a relatively short time period, but the administration process involved from the initial visa application to undertaking the required NMC checks will also take time before a true indication of the impact on numbers is felt.
- 2.71 Early evidence from the NMC suggests there has been a marked increase in the number of applicants who have sat the NMC's Objective Structured Clinical Exam (OSCE), the test for competency in nursing and midwifery for those who have trained outside the UK. In October 2015, 71 non-EEA nurse and midwifery applicants sat the exam. This rose to 125 the following month, 208 in December 2015 and to 333 in January 2016. The trend increase in these numbers may provide an indication of greater numbers of non-EEA nurses wanting to come to the UK since the SOL decision. This needs to be borne in mind as we consider the overall impact on the limited number of Tier 2 (General) places available for all occupations.

### **(iv) Spending Review and Autumn Statement 2015**

- 2.72 In its Autumn Statement 2015, the Government made a number of announcements that will potentially impact on the health sector generally and the supply of nurses specifically:

## Review of nursing

- NHS England will receive £10 billion more in funding a year in real terms by 2020-21 than in 2014-15.
- By 2020, health and social care will be integrated across England, joining up services between social care providers and hospitals.
- Bursaries for student nurses will also be replaced by loans, and the cap on the number of centrally commissioned places for nurses and midwives that can go into training each year will be removed.
- Councils will be given even more powers over decision-making in their local areas. They will be able to add 2 per cent on council tax to contribute towards the cost of social care in their areas, if they wish.
- The Government intends to introduce a new nursing associate role at Agenda for Change Band 4 (one band below the level migrant nurses are recruited). We will discuss how these proposed changes might affect the demand for and supply of migrant nurses later in this report.

### 2.6 Recent MAC reports with relevance to recruitment of migrant nurses

#### (i) Partial review of the shortage occupation list (February 2015)

- 2.73 The MAC was commissioned in autumn 2014 to undertake a review of the SOL for a small number of occupations/sectors. One of these was healthcare, though with a focus only on the NHS sector.
- 2.74 Our recommendation at the time was that nurses should not be added to the SOL. We attached a lot of weight to the comprehensive evidence we had received from the Department of Health (DH) and the Centre for Workforce Intelligence (CfWI), where they had argued against inclusion of nurses on the list. When we delivered our report to Government in February 2015, it was still possible for employers in the health sector to recruit non-EEA nurses under the RLMT route of Tier 2 (General). As reported above, once the monthly Tier 2 limit was reached from June 2015, this limit impacted significantly on the numbers of RCoS granted for nurses.

#### (ii) Review of Tier 2 (December 2015)

##### *Salary thresholds*

- 2.75 Part of our commission from the Government in 2015 to review Tier 2 asked us to consider the economic rationale for, and the impact on net migration of, setting new minimum salary thresholds, with a focus on ensuring that Tier 2 migrants are not undercutting the resident labour market.
- 2.76 We recommended that the minimum salary threshold for Tier 2 be set at the 25th percentile (£30,000). However, we recognised that public sector pay restraint has resulted in inflexible responses to wage pressures. We recommended that the thresholds for the predominantly public sector

occupations should gradually be increased over time to reach the £30,000 threshold. It is our view that salaries should be raised in line with the increased skill requirement of NQF6+, and that as public sector occupations such as nursing and teaching correspond to this skill level, they should not be offered any permanent exemption from increased salary thresholds.

### *Immigration Skills Charge (ISC)*

- 2.77 We assessed that an ISC will incentivise employers to reduce their reliance on employing migrant workers and to invest in training and upskilling UK workers and that it will also provide a source of funding to help with this training and upskilling. We therefore recommended that the ISC be used in addition to raising salary thresholds. We considered the arguments for exempting the public sector, but decided that given that the aim of the ISC is to influence employer behaviour, public sector organisations are employers like any other and should be incentivised to consider the UK labour market before recruiting through Tier 2. If the ISC is implemented in this way, it will increase the cost of recruiting nurses from outside the EEA.

## **2.7 Summary**

- 2.78 This chapter has described what is essentially a complex system of health and social care across the UK. Furthermore, these systems have undergone significant change in recent years, with the prospect of more change to come. All of this is taking place against a backdrop of funding pressures for the delivery of public healthcare.
- 2.79 As nurses constitute the largest single professional staff group in the UK healthcare system, they have been, and will inevitably continue to be, impacted by these changes and pressures. We have tried as far as possible in this chapter to provide reasonable quantitative estimates of volumes and trends in nursing across the four countries of the UK, as well as how this is affected by the training of new nurses and the recruitment of nurses from outside of the EEA.
- 2.80 The last two years have seen a rapid increase in the number of foreign-born nurses that health sector employers are bringing or are trying to bring into the UK. Most of this is in the NHS sector indicating an increasing reliance on non-EEA nurses though, because of the immigration cap for all skilled workers, health sector employers have experienced difficulty in accessing the migrant nurses they say they need.
- 2.81 With this in mind, the next chapter begins to examine the case for whether or not there is currently a nationwide shortage of nurses.



## Chapter 3: Shortage

### 3.1 Introduction

- 3.1 Are nurses currently in shortage? This chapter takes a high-level view of nursing shortage, utilising three approaches: our standard assessment of top-down indicators of shortage (based on national data to examine pay, vacancies, and employment of nurses); an examination of detailed nurses vacancy data, distinguishing as far as possible by healthcare sector and by region; and partner evidence on shortage, with a focus on whether any shortage is localised or national and whether any shortages are more acute in certain nursing specialities. In Chapter 4 we consider in greater detail factors that may contribute to shortage.
- 3.2 As we saw in Chapter 2, nursing is an occupation that comprises four fields. Each field has within it a number of different specialties and also different job titles. The whole of the nursing occupation (SOC 2231) is presently included on the Shortage Occupation List (SOL) and so we have looked at national level data relating to this standard occupational classification (SOC) code. Partners told us that shortages may also exist within fields and within job titles as well as across the whole nursing occupation. We rely on partner evidence to tell us to what extent this is the case.
- 3.3 We also outlined in Chapter 2 the extent to which health and care are devolved issues and we do examine in this report separate data relating to England, Scotland, Wales and Northern Ireland where this is available and relevant. However, our commission from the government requires us to consider whether there is a UK-wide shortage (along with a separate shortage in Scotland) and so we focus initially on the national level data.

### 3.2 Top-down shortage indicators

- 3.4 The MAC methodology for identifying shortage is now well established. Our view is that there is no single measure of shortage and that there are several indicators that should be used to assess shortages in the labour market. Our top-down shortage indicators, as described in Migration Advisory Committee (2008), seek to identify national level shortages in an

## Review of nursing

occupation, identified using the SOC system. The available data can only be drilled down to the four digit SOC level, and therefore relate only to the whole of an occupation.

- 3.5 We use these indicators alongside our assessment of more granular, 'bottom-up' partner evidence to reach a judgement as to whether occupations, or particular job titles within occupations, are in shortage across the UK.
- 3.6 We presently use ten indicators of shortage. Each indicator is compared against a benchmark as defined in MAC (2008). Our top-down analysis of national level data provides an indication that nurses are in shortage - nurses pass five of the 10 available shortage indicators (Table 3.1).

<b>Table 3.1: Top-down shortage indicators for SOC 2231 Nurses - 2015</b>			
Occupation passes 5 out of 10 available indicators			
	Spring 2015		Spring 2015
<b>P1:</b> Percentage change of median real pay (over 1 year)	-0.95	<b>V2:</b> Percentage change of employment level (over 1 year)	5.81
<b>P2:</b> Percentage change of median real pay (over 3 years)	-5.04	<b>V3:</b> Percentage change of median paid hours worked (over 3 years)	0.00
<b>P3:</b> Return to occupation	-0.12	<b>V4:</b> Change in new hires (over 1 year)	0.62
<b>I1:</b> Change in median vacancy duration (over 1 year)	Data not currently available <sup>2</sup>	<b>E1:</b> Skill-shortage vacancies/total vacancies	39.52
<b>I2:</b> Vacancies/claimant count	Data not currently available <sup>2</sup>	<b>E2:</b> Skill-shortage vacancies/hard-to-fill vacancies	68.62
<b>V1:</b> Percentage change of claimant count (over 1 year)	-41.75	<b>E3:</b> Skill-shortage vacancies/employment	1.55
<b>Total employment in this 4-digit occupation is approximately 630,000</b>			
Source: Labour Force Survey - 2014 Q4 to 2015 Q3			

- 3.7 Notably, nurses do not pass any of the three indicators that examine pay (P1, P2 and P3). These indicators represent percentage change of median real pay (over 1 year), percentage change of median real pay (over 3 years) as well as a measure of the relative pay in the occupation compared to similarly skilled occupations.
- 3.8 We look at pay indicators because we consider it reasonable to expect to see an attempt being made by employers to resolve shortages through increasing pay (making occupations more attractive to native workers) before resorting to recruitment of non-EEA workers. A shortage would normally be expected to manifest itself in pay increases and the three pay indicators are based on the principle that, where a shortage is present, wages should rise as employers compete to secure the scarce labour. However, the majority of nurses work in the NHS, where pay is fixed

<sup>2</sup> Official data on vacancies at the 4-digit SOC level are no longer published by the Department for Work and Pensions following a change to the reporting system. The SOC 2000 data is still collected in the background but is not collated for reporting purposes.

according to the Agenda for Change banding framework (discussed in more detail in Chapter 4). As such, for NHS employers there is limited flexibility to raise pay in an attempt to recruit nurses.

- 3.9 In fact, constraints on public sector pay growth mean that nurses' pay has fallen in real terms in recent years. We address the question of whether increased pay is a viable way of resolving any current shortages of nurses in Chapter 5.
- 3.10 Excluding pay, nurses pass five of the seven remaining indicators – a strong indication of shortage (in any case, passing five out of 10 indicators means that nurses are considered to be in shortage under the MAC's 'top-down' approach). In our previous review of shortages within the nursing occupation, nurses passed only four indicators (Migration Advisory Committee, 2015a). This time round, nurses have additionally passed the indicator *E1: skill shortage vacancies as a percentage of all vacancies*, taken from the 2015 Employer Skills Survey carried out by the UK Commission for Employment and Skills (UKCES, 2016).
- 3.11 We set out below the vacancy data we have taken into account and then highlight some of the evidence on shortage that we received from partners. We dovetail these top-down and bottom-up approaches in order to reach an overall conclusion as to whether nurses are in shortage.

### 3.3 Vacancy data

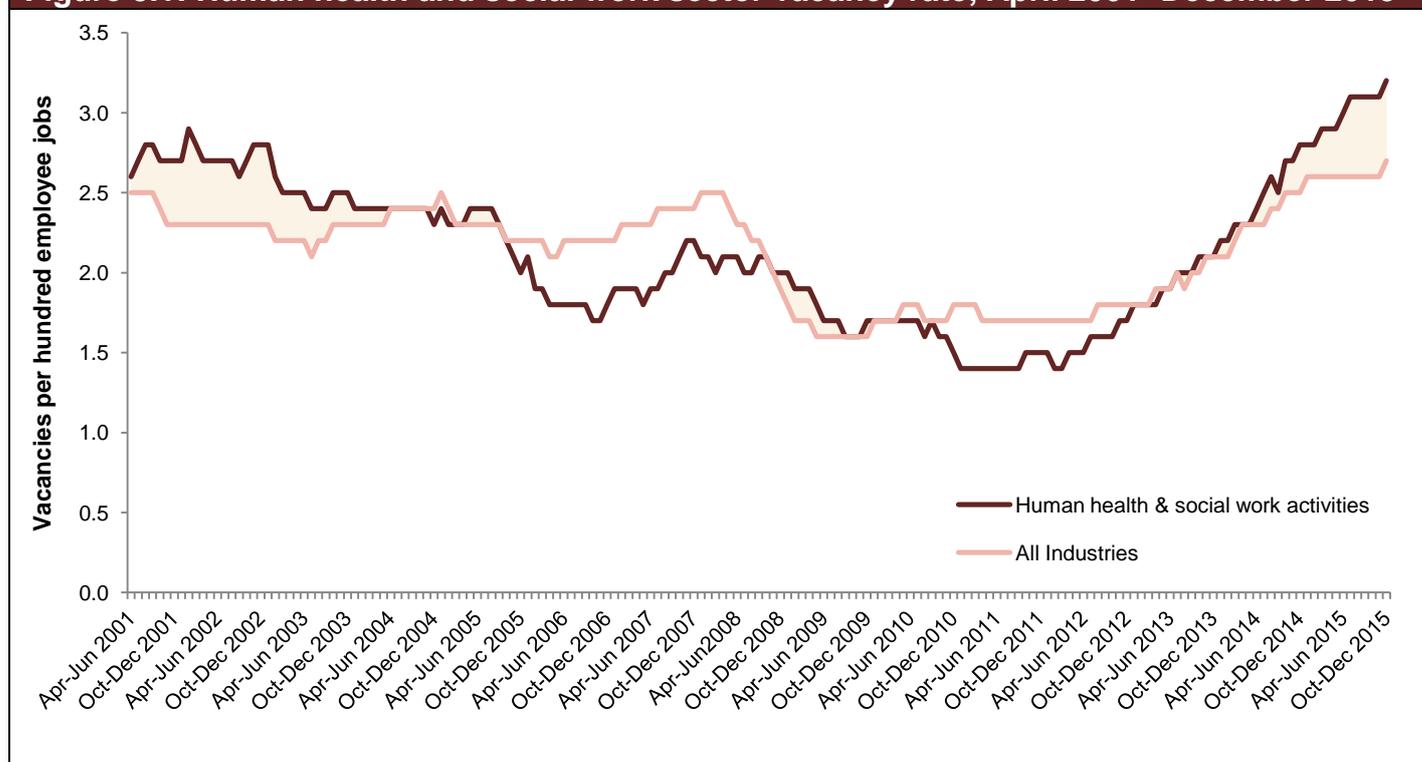
- 3.12 We consider vacancies to be an important indication of shortage. According to the Office for National Statistics (ONS, 2002), a job vacancy is a paid post that is newly created, unoccupied, or about to become vacant and:
- the employer has taken active steps to fill the position, and is prepared to take more steps; and
  - it is available for a suitable candidate, and open to people from outside the business or organisation concerned, either immediately or in the near future after the necessary recruitment procedure.
- 3.13 In order to compare the vacancy picture between occupations, industries, organisations or regions of different size, we measured the total number of vacancies as a percentage of employment in that occupation, industry, organisation or region. We call this the vacancy rate. We are also interested in the number of vacancies which are hard to fill – those where employers have to advertise a vacancy for over three months before it is filled.
- 3.14 It is important to note, however, that whilst we use the definition of vacancy rate above, data provided by partners may use a definition that differs slightly from this. It is not always possible to reconcile these differences. We highlight in the text of this report where these differences in data occur.

## Review of nursing

3.15 First, we consider the human health and social work sector as a whole, and then look at data at the occupational level for all nurses (NHS, care, agency and independent nurses). We then examine more detailed data, where available, on vacancies in the NHS and the care and independent sectors, breaking down by region where possible.

3.16 Figure 3.1 shows the vacancy rate in the human health and social work sector compared to that of all other industrial sectors. According to the industry data, vacancies in this sector have risen well above the UK average in the year to December 2015 (ONS, 2015). In October to December 2015, the sector had 3.2 vacancies per hundred jobs compared to 2.7 across the UK. Whilst the Labour Force Survey showed that, in 2015, nurses accounted for only 14 per cent of employment within the human health and social work sector, they are the largest single occupation within it.

**Figure 3.1: Human health and social work sector vacancy rate, April 2001- December 2015**

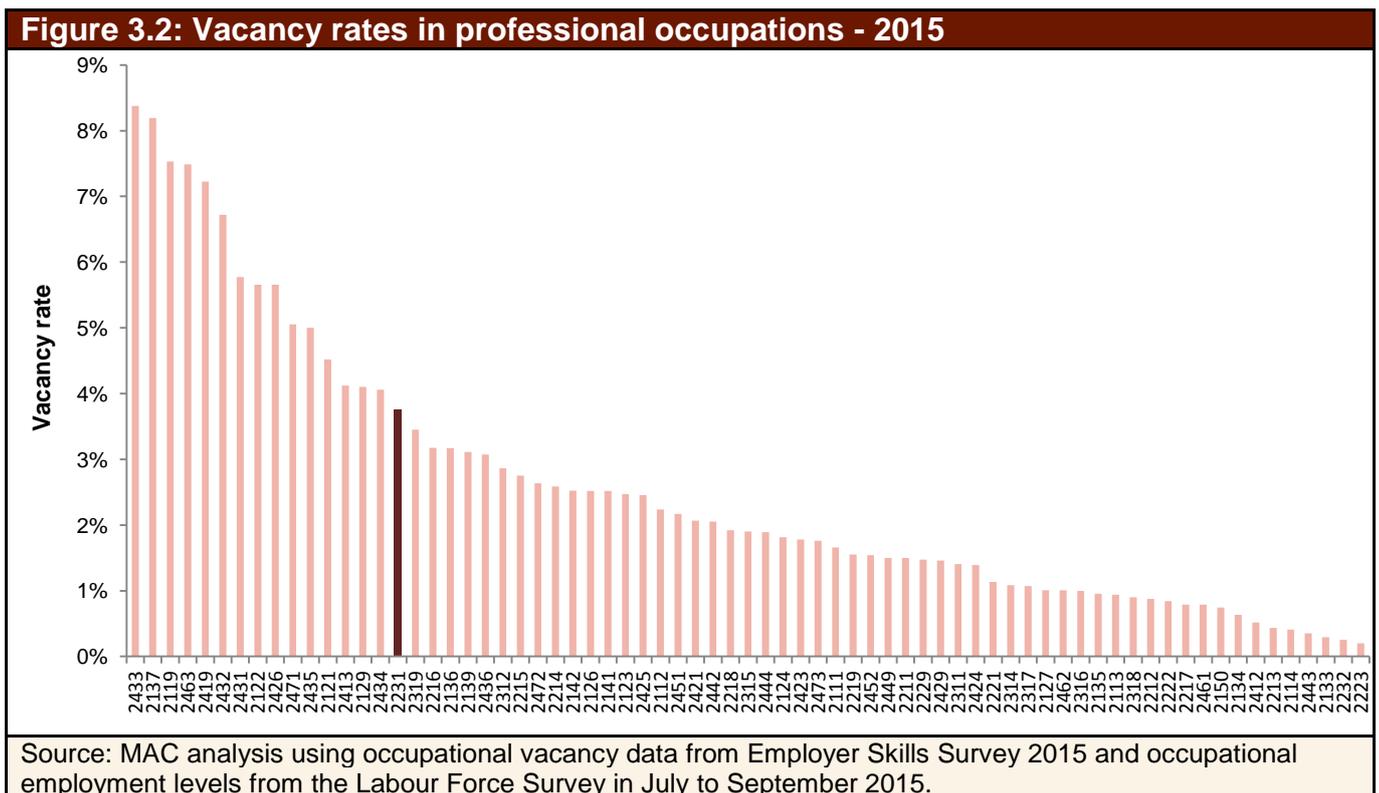


Source: Office for National Statistics (2015)

Notes: Shaded sections indicate periods where vacancy rate in the human health and social work sector exceeds the average across all industries.

3.17 The current difference between the vacancy rate in the human health and social work sector and the overall vacancy rate looks similar to the difference during 2001 and 2002. In that period, there was a large increase in the number of nurses recruited from abroad. We saw in Chapter 2 that, according to the Nursing and Midwifery Council (NMC), over 16,000 nurses from outside the EEA registered with the NMC in 2001-02.

- 3.18 Data on vacancies at an occupational level are no longer published on NOMIS (NOMIS 2016) – a service provided by the Office for National Statistics (ONS), to give access to the most detailed and up-to-date labour market statistics. For this report, we calculated occupational vacancy rates using the Labour Force Survey to measure the level of employment in each occupation and using the Employer Skills Survey 2015 to measure the number of vacancies in each occupation.
- 3.19 Figure 3.2 shows how, according to our analysis, nursing vacancy rates compare to vacancy rates in other professional occupations. By this measure, the overall vacancy rate for nurses is 3.7 per cent. This is towards the top end of the distribution but there are other professional occupations with significantly higher vacancy rates (e.g. SOC 2433 Quantity surveyors and SOC 2137 Web design and development professionals).
- 3.20 It is worth noting that while the Employer Skills Survey is currently the best available data source that allows us to consider vacancy rates across occupations, it is a sample-based survey and may differ from more detailed administrative vacancy data provided directly by employers.



## Review of nursing

### NHS Vacancies

- 3.21 We looked, first, at the available vacancy data for NHS nurses in England overall and then specifically for London, and then for each of the devolved administrations.
- 3.22 Ideally, we would like to have seen vacancy data for individual NHS trusts as well as vacancy data for the care and independent sectors broken down at a regional level. In practice, the available vacancy data is patchy and it is not often possible to form a complete picture. While excellent vacancy data is available for NHS trusts in Northern Ireland and Scotland, vacancy statistics for trusts in England are no longer routinely published, an unfortunate decision as it is vastly more difficult to fix a problem that cannot be quantified. Data are also not consistently available for Wales.
- 3.23 Because of the lack of a clear authoritative source on vacancy data, we considered, in turn, a wide selection of available vacancy data, some published and some provided to us by partners. Due to differences in methodology, time periods and data sets, the figures are sometimes contradictory. Where possible, we highlight where these discrepancies occur, however, the methodology is not always sufficiently transparent for us to do so. It is our view that, in the absence of any authoritative single source, it is only through considering each of these alternative sources that we can build up a more complete picture of nursing vacancy rates throughout the NHS.
- 3.24 The Department of Health and Health Education England told us that National Institute for Health and Care Excellence (NICE) guidance states that health organisations should aim for at most a 5 per cent vacancy rate to accommodate operational flexibility needs. It is, therefore, important to bear this figure in mind when considering NHS vacancy rates. However, this is a maximum value and, therefore, a vacancy rate of less than 5 per cent can still indicate shortage.

#### *England*

- 3.25 Health Education England (HEE), the body responsible for workforce planning for the NHS in England, provided the most complete and up to date picture concerning the demand and supply gaps for nursing in England.
- 3.26 Table 3.2 reproduces their breakdown of overall nursing demand and supply across the NHS in England as of March 2015. In total, they estimated a vacancy rate of 9.4 per cent. For adult nurses, who account for more than two thirds of the total, the vacancy rate was 9.8 per cent. According to HEE, there was wide variation in vacancy rates between specialisations. District nurses had the highest demand and supply gap for adult nurses in England at 21.8 per cent while maternity service nurses were in surplus.

**Table 3.2: Vacancies for Nurses in England – March 2015**

Nursing field	Speciality	Supply	Demand	Gap
<b>Adult</b>	Acute, Elderly & General	175,273	194,642	19,369 (10.0%)
	Community	29,957	32,650	2,693 (8.2%)
	District Nurses	5,266	6,731	1,466 (21.8%)
	Maternity Services (Excluding Midwives)	2,929	2,538	-390.6 (-15.4%)
	Other	1,273	1,579	306 (19.4%)
	<b>Adult Total</b>	<b>214,698</b>	<b>238,141</b>	<b>23,443 (9.8%)</b>
<b>Children's</b>	Community Settings	415	782	367 (46.9%)
	Paediatrics	18,070	18,170	100 (0.6%)
	Neonatal	3,829	4,945	1,116 (22.6%)
	Health Visitors	11,613	12,227	614 (5.0%)
	School Nursing	3,059	3,546	488 (13.8%)
	<b>Children's Total</b>	<b>36,986</b>	<b>39,670</b>	<b>2684 (6.8%)</b>
<b>Learning Disability</b>	Community Settings	1,944	2,372	428 (18.0%)
	Other	1,847	1,925	78 (4.1%)
	<b>Learning Disability Total</b>	<b>3,791</b>	<b>4,297</b>	<b>506 (11.8%)</b>
<b>Mental Health</b>	Community Settings	15,429	17,583	2154 (12.3%)
	Other	22,314	24,086	1772 (7.4%)
	<b>Mental Health Total</b>	<b>37,743</b>	<b>41,669</b>	<b>3,926 (9.4%)</b>
<b>Other</b>	<b>Post-Registered Learners Total</b>	<b>1,889</b>	<b>1,986</b>	<b>97 (4.9%)</b>
<b>Total</b>		<b>295,106</b>	<b>325,763</b>	<b>30,656 (9.4%)</b>

Source: Health Education England response to MAC call for evidence.

Notes: These figures show the supply (measured by current Whole Time Equivalent (WTE) contracted staff in post) and demand (measure of WTE posts) provided by individual NHS trusts to Health Education England. The gap between supply and demand is not necessarily a vacancy – organisations may plan to use bank, agency or overtime to give themselves operational flexibility.

3.27 In the HEE evidence, however, the definition of vacancy differs from the one we set out at the beginning of this chapter. A vacancy is defined by HEE as the difference between the number of established posts and current contracted employment, regardless of whether there is an active attempt to hire staff to fill the excess posts. In some cases, organisations may plan to use bank, agency or overtime staff in place of these excess posts to give themselves operational flexibility. If, for example, budgetary constraints meant there was no attempt made to fill empty posts, these

## Review of nursing

would be considered vacancies in this evidence but they would not be indicators of shortage. As such, the vacancies in this evidence will necessarily be higher than the vacancy rate using the definition set out previously.

- 3.28 The Department of Health told us that the vacancy situation in the NHS had worsened over the past year. As of 1 April 2014, acute and community NHS Trusts in England were reporting 15,489 full-time equivalent (FTE) vacancies for adult nurses, corresponding to a vacancy rate of 6.5 per cent. The Department said that the vacancy rate had now reached 10 per cent, citing the HEE figures presented above. The Department also set out how the overall vacancy rate for adult nurses varied across England, stating that all regions had vacancy rates above 5 per cent but that the highest rates were in London.

*“The overall nursing vacancy rate in the NHS was found to be 10 per cent by NHS Employers; however, there was variation within this figure from 7 per cent in Health Education North East, Health Education North West and Health Education South West, to 18 per cent in Health Education North Central and East London and Health Education South London... These figures are all higher than the NICE recommended maximum vacancy rate for nursing of 5 per cent.”*

Department for Health response to MAC call for evidence

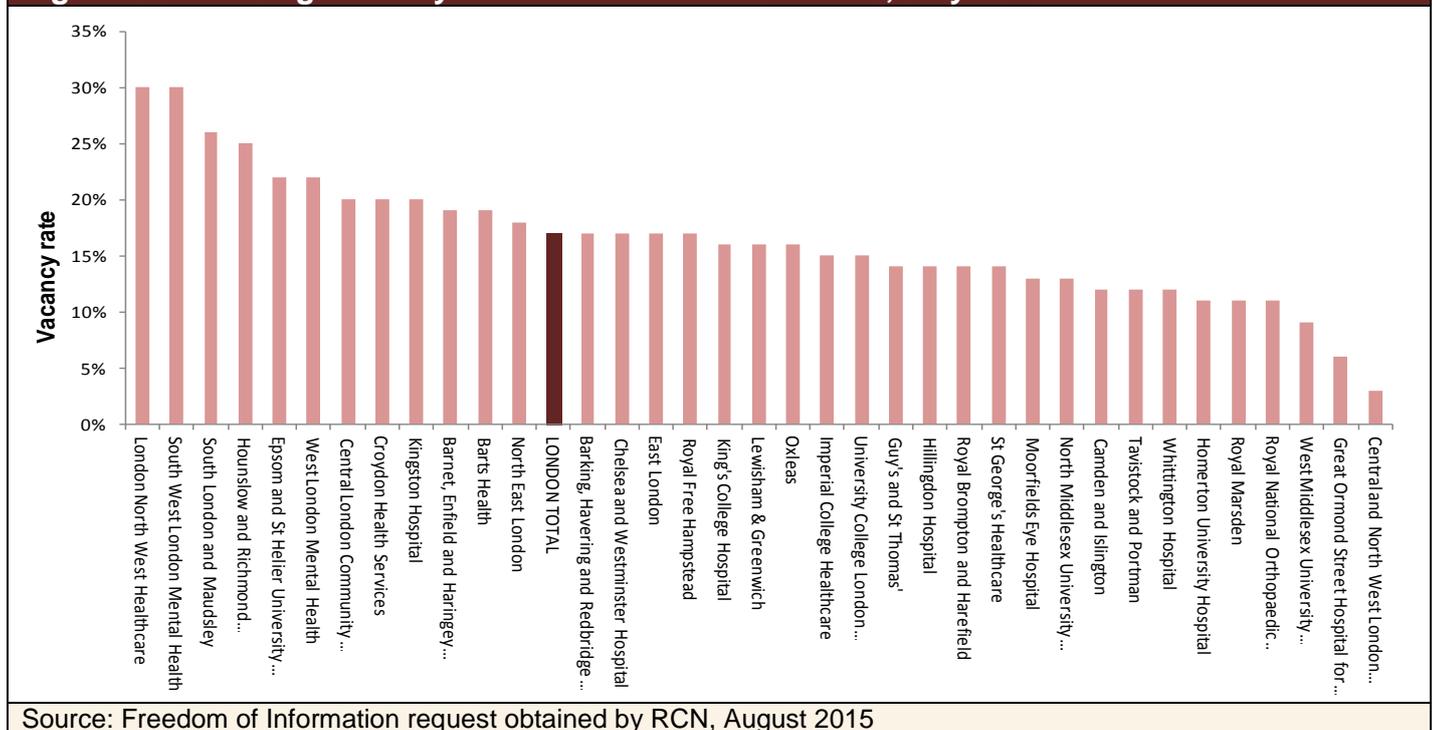
- 3.29 The Health and Social Care Information Centre (HSCIC) produces data on staffing levels across the NHS in England. HSCIC have recently begun producing experimental vacancy statistics, collected through the NHS jobs portal, which can be examined for evidence as to the extent to which advertised vacancies lead to successful appointments. Variation in this measure could indicate that some NHS trusts have more difficulty filling vacancies than others.
- 3.30 These data are experimental and may considerably underestimate the number of vacancies as each advertisement on NHS jobs is registered as one vacancy whereas it is often the case that a single advertisement will be for several vacancies. The result may, therefore, underestimate the number of vacancies. In addition, differing regional work practices for updating the vacancy on the NHS job portal once it has been filled could account for part of any regional variation.
- 3.31 Whilst these data only show vacancies between March and November 2014, and include midwifery roles as well as nursing roles, they do suggest that there is variation across regions. For example, between March and May, the proportion of successful appointments to vacancy adverts for registered nursing and midwifery varied from as low as 8 per cent (in Central and East London) to as high as 50 per cent (in the South West) (HSCIC 2015).

3.32 As of 23 January 2015, there were 5,431 individual advertisements for a nurse on NHS jobs in England, which represents about 1.8 per cent of the current HEE Whole-Time Equivalent (WTE) nurse employment total of 295,106. This is a lower bound for the vacancy rate since, as we have said; an unknown number of these advertisements are for multiple vacancies. The usefulness of these data would be greatly increased by simply requiring those employers who are posting adverts to indicate the number of jobs they are seeking to fill.

*London*

3.33 The responses by NHS trusts in London to a Freedom of Information request made by the Royal College of Nursing (RCN) indicated that London NHS trusts were carrying a total of 10,140 vacancies in July 2015, equivalent to a 17 per cent vacancy rate (RCN, 2016). This varied substantially from 3 per cent in Central and North West London NHS Trust to 30 per cent in London North West NHS Trust (Figure 3.3).

**Figure 3.3: Nursing vacancy rates in London NHS Trusts, July 2015**



Source: Freedom of Information request obtained by RCN, August 2015

3.34 The average vacancy rate across London appears to be a lot higher than the national vacancy rates for England reported above. Further, the data show a significant variation in vacancy rates among trusts in London and suggest that factors other than location alone contribute to trusts' ability to fill vacancies.

3.35 It is unfortunate that detailed trust vacancy data is not available in England. Ideally, we would be able to extend the picture for vacancies in London set out in Figure 3.3 across the rest of England but currently this is not possible.

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3.36 Therefore, the lack of available data does not allow us to make a conclusive statement on the distribution of vacancies in the NHS in England. However, each of the available data sources that relate just to the NHS in England indicate a vacancy rate higher than the maximum recommended vacancy rate of 5 per cent and are consistent with nurses being in shortage across England.

### *Devolved Administrations*

3.37 Two of the devolved administrations, Northern Ireland and Scotland, have a richer source of available vacancy data than England. However, Wales, like England, does not routinely publish detailed trust vacancy data covering the NHS.

3.38 Data from Northern Ireland show that the vacancy rate in HSC<sup>3</sup> trusts (for nursing, midwifery and health visiting) was just below 3.8 per cent across the country in March 2015 (HSC, 2015). The distribution of these vacancies varied significantly across the country. Belfast HSC Trust reported a vacancy rate of 7.7 per cent whilst South Eastern HSC Trust reported a vacancy rate of under 0.5 per cent.

3.39 In Scotland, the most recent data show an average nursing vacancy rate of 3.9 per cent in September 2015 (NHS Scotland, 2015). As is the case in Northern Ireland, the published vacancy rates varied greatly by region as NHS Orkney reported a 10.5 per cent vacancy rate while NHS Dumfries & Galloway reported a vacancy rate of 0.5 per cent.

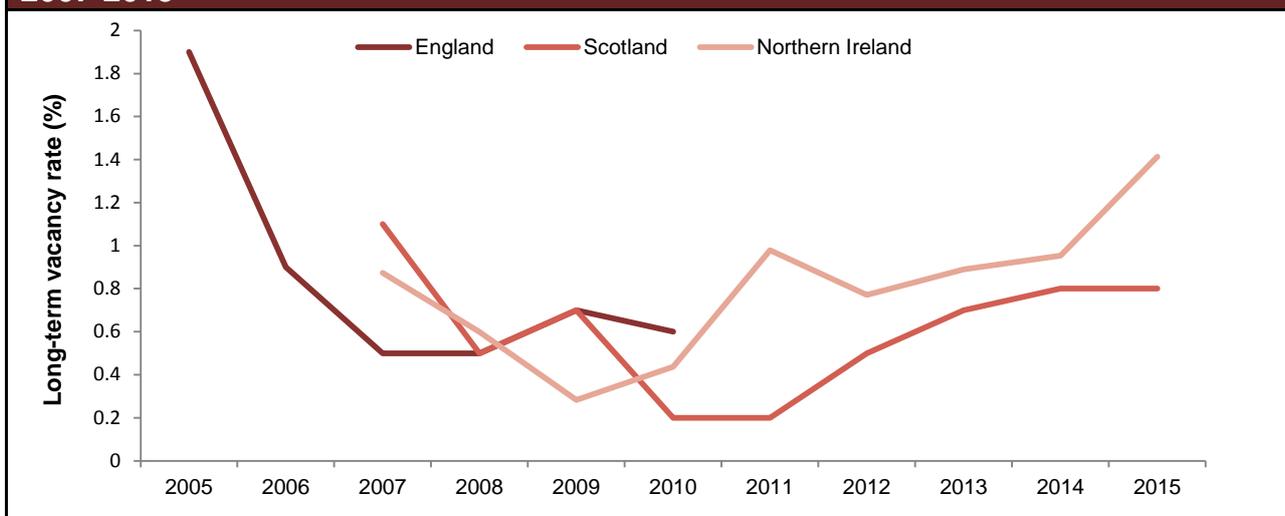
3.40 Wales, similarly to England, no longer publish vacancy statistics. However, responses from health boards in Wales to a recent Freedom of Information made by Plaid Cymru showed that there were 1,240 nursing vacancies in September 2015, indicating a vacancy rate across Wales of 5.6 per cent (Plaid Cymru, 2015).

3.41 In addition, both Northern Ireland and Scotland provided information about long-term vacancies; vacancies advertised for at least three months before being filled. These data are helpful as they provide an insight into whether vacancies are particularly hard to fill. In Northern Ireland, the latest figures showed a long-term vacancy rate of 1.5 per cent (HSC, 2015); in Scotland it was 0.8 per cent (NHS Scotland, 2015). Figure 3.4 compares these long-term vacancy rates over time and shows that current long-term vacancy rates are relatively high compared to previous years.

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<sup>3</sup> Health and Social Care in Northern Ireland (HSC) is the designation of the publicly funded service responsible for the administration of the public health and other social care services in Northern Ireland.

**Figure 3.4: Long-term vacancy rates for qualified nurses by region, September 2007-2015**



Source: Long-term vacancy rates are three month vacancies expressed as a percentage of three-month vacancies plus staff in post (headcount). Vacancy rates for England are taken from the NHS Vacancy Survey, March 2005-2010. Vacancy rates for Scotland are taken from NHS Scotland Workforce Statistics, September 2007-2015. Vacancy rates for Northern Ireland are taken from the Northern Ireland Health and Social Care Workforce Vacancy Survey, September 2007-March 2015. No comparable data was found for Wales. Includes midwives also qualified as nurses.

- 3.42 It is unfortunate that insufficient data are available for England and Wales to create a current national picture. The last set of long-term vacancy rates in England, which we are aware of, were published in the HSCIC NHS vacancy survey in 2010.
- 3.43 Table 3.3 below summarises each of the available sources of data for vacancy rates in the UK alongside our analysis of the vacancy rate in Wales. However, it is important to note that in each of these cases the vacancy rate differs from the ONS definition above in that it simply measures the difference between the number of established jobs and current employment, regardless of whether there is an active attempt to hire staff to fill vacant posts. As such, each is likely to represent an upper bound for the vacancy rate in their specific region.
- 3.44 Whilst only data for England and Wales indicate a national vacancy rate above the 5 per cent recommended maximum, these data cover the vast majority of nursing posts within the NHS in the UK. Local data indicate that pockets with vacancy rates above 5 per cent are spread throughout the UK. Additionally, as we stated above, vacancy rates of less than 5 per cent do not necessarily indicate an absence of shortage.

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**Table 3.3: NHS Vacancy rates for nursing across the UK – 2015**

Source	Vacancy Rate				
	<i>England</i>	<i>London</i>	<i>Northern Ireland</i>	<i>Scotland</i>	<i>Wales</i>
Health Education England	9.4%				
Royal College of Nursing		17%			
Northern Ireland Health and Social Care Workforce Vacancies			3.8%		
NHS Scotland				3.9%	
MAC analysis of Plaid Cymru Freedom of Information request					5.6%

Notes: Sources are not directly comparable due to differing definitions of vacancy rate.

3.45 On balance, we consider that the available data make it reasonable to conclude that the NHS in the UK as a whole is experiencing a nurse vacancy rate that is indicative of a shortage of nurses. It appears that each of the devolved administrations has a vacancy rate lower than that for England which is, in turn, substantially lower than that in London. The severity of nursing shortages in the NHS, therefore, varies significantly across the UK.

### Care and independent sector vacancies

3.46 We are not aware of any national level data on nurse vacancies in the care and independent sectors across the whole UK.

3.47 Skills for Care, the employer-led workforce development body for adult social care in England, told us that the National Minimum Data Set for Social Care (NMDS-SC) does provide a useful overview of vacancies in the social care sector in England. The NMDS-SC holds data on staff retention rates, qualifications and vacancies for around 25,000 care providing locations in England. According to Skills for Care the NMDS-SC vacancy rate for nurses in social care in England was 8 per cent in September 2014.

3.48 Care England, a representative body for care providers, carried out a survey of its members in response to our 2014-15 partial review of the SOL. The survey received responses from 26 organisations covering some 2,000 care homes and employing 8,900 nurses. All respondents reported difficulties in recruiting sufficient nursing staff, with an average vacancy duration of 10 months.

3.49 As with any survey of this kind, we are cautious as to how representative these results are of the entire care home population. Nevertheless, the results do indicate a difficult recruitment climate for those who responded.

3.50 BUPA, who employ 5,000 nurses and senior nurses in 280 care homes and five care villages across the UK, caring for over 40,000 people, reported a vacancy rate of 13 per cent for nurses nationally across the UK.

Additionally, Four Seasons Healthcare reported carrying around 500 vacancies for nurses at any one time, a vacancy rate of around ten per cent.

- 3.51 The vacancy data in relation to nurses in the care and independent sectors that we were able to access, while far from comprehensive, do indicate that these sectors are also experiencing difficulties in obtaining sufficient numbers of nurses.

### 3.4 Partner evidence on shortage

- 3.52 Over the previous 14 months or so, between our partial review of the SOL, the follow-up to that review, and this present review of nurses, we have received extensive evidence from a wide range of bodies across the health, care and independent sectors relating to nurses and whether they are in shortage. This section describes some of the evidence we received on overall shortages across the sectors, followed by evidence on shortages in particular regions and then shortages within nursing specialities.

#### NHS bodies

- 3.53 The Department of Health, in December 2014, told us that there was not a national shortage of nurses in the health sector. We discuss the evidence they provided to us in Chapter 5. Their evidence to us for this review said that, in summary, there is a shortage of nurses across all four fields of nursing and within several specialties in those fields. The Department cited staffing projections made by the Centre for Workforce Intelligence (CfWI), an independent body commissioned by the Department to advise on workforce planning. These projections were compared with HEE demand and supply projections for the NHS nurse workforce in England up to 2019. The demand-supply gap in 2014 was estimated to be about 13,000 full-time equivalent (FTE) staff (HEE, 2015a). CfWI projections indicated that this gap is estimated to grow to about 21,500 FTE by 2019, in the absence of any initiatives to reduce the gap. This figure does not take account of the anticipated nursing needs of the care sector.
- 3.54 The Department said that current and planned initiatives to reduce the gap should, if successful, drive supply above demand for the NHS nurse workforce by 2019 but that there remained a risk of continued workforce pressures if these initiatives failed to meet the required outcomes. We look in Chapter 5 at whether these initiatives provide grounds for confidence in the Department's 2019 target date for achieving a nursing supply equilibrium.
- 3.55 Monitor, the sector regulator for NHS foundation trusts in England, told us that the supply of UK and EEA nurses is not sufficient for trusts to fill their nursing vacancies. NHS England and NHS employers echoed this and said that hospitals across England were struggling to recruit enough nurses.

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### NHS trusts

- 3.56 NHS trusts from across the UK told us that nurses were in shortage and described their experiences of this and what it meant for patients. For example, Royal Surrey County Hospital NHS Foundation Trust raised concerns over meeting patient needs whilst experiencing nursing shortages.

*“It is abundantly clear that there is a critical shortage of registered nurses in the UK...we are extremely concerned about the impact that the UK shortage of nurses is having on both patient care and nurses within our Trust and the wider NHS.”*

Royal Surrey County Hospital NHS Foundation Trust response to MAC call for evidence

- 3.57 Other NHS partners highlighted an ongoing struggle to fill nursing vacancies. They told us that the level of vacancies was such that they often resorted to agency or bank nurses to maintain safe staffing levels. In some instances, even when trusts were successfully recruiting nurses, they could experience periods of time when they lost more staff than they hired.

*“...there are 24 leavers each month and 19 starters. We normally have approximately 100 posts on offer and a further 75 in the advertised pipeline... We are never able to reach our full complement of staffing numbers due to the national shortage of staff.”*

Basildon and Thurrock University Hospitals NHS Foundation Trust response to MAC call for evidence

*“Wards are currently struggling with trying to ensure there is adequate staffing [of nurses] on wards for each shift and in order to do this the wards have to rely on bank and agency nurses...”*

Barking, Havering and Redbridge Hospitals NHS Trust response to MAC call for evidence

- 3.58 By way of contrast to the majority of NHS evidence we received, NHS Greater Glasgow and Clyde, Scotland’s largest Health Board, told us that they had not experienced a shortage of nurses.

*“At present we do not generally experience difficulty in recruiting registered nurses in the West of Scotland.”*

NHS Greater Glasgow and Clyde response to MAC call for evidence

### Care and independent sectors

- 3.59 Representatives from the care and independent sectors also provided us with evidence of nursing shortages. For example, Four Seasons Health Care told us that the need to address the shortage of nurses in the UK was immediate and growing. They said that, despite extensive recruitment and retention efforts, their vacancy rate remained around 10 per cent. By comparison, vacancy rates for non-nursing positions at Four Seasons Health Care are generally less than 5 per cent.
- 3.60 Care England submitted several case studies about the recruitment difficulties facing the care sector. One case study highlighted the recruitment experience of a large care provider with 7,000 residents across 121 homes. The provider had 189 nursing vacancies and made offers to 810 nurses but lost a third of these recruits to the NHS before the recruits had commenced work. They also told us how this care provider purchased the names of 8,000 nurses in the North of England and wrote to them all, offering a £15,000 golden handshake to relocate to the South, and a £35,000 salary on relocation. They received no response to the offer.
- 3.61 The Macklin group, which operates a number of care homes in Northern Ireland, stated that they have been consistently understaffed by between 10-15 per cent of required nurses for over 2 years despite all their efforts at recruitment and offering some of the highest pay rates in the care sector.

### Regional variations

- 3.62 While the majority of partners across the health and care sectors told us that nursing shortages were widespread and more or less uniform across the UK, some highlighted that there were significant regional variations.
- 3.63 HEE told us that regional variation may be the result of local, geographical circumstance (such as the employment being in a remote, or less desirable, location), or organisation development issues (the perception or reputation of the trust being regarded with suspicion by prospective recruits). North Tees and Hartlepool NHS Foundation Trust told us that the lack of attractiveness of an area can heighten shortages. NHS England echoed these views.

## Review of nursing

*“The results from NHS Employers survey highlight the variation in organisations and different experience in inner city, rural and less desirable parts of the country. Some areas are finding it harder to recruit due to their proximity to other providers thus allowing mobility of staff between organisations or due to the high cost of living in particular geographic areas including a number of cities outside of London.”*

NHS England response to MAC call for evidence

- 3.64 Some partners identified specific areas that experienced higher levels of shortage. London and areas within the devolved administrations were the locations most frequently cited. Additionally, partners highlighted certain cities and high cost regions that can be prone to nursing shortages.

*“It is fair to note that this [shortage] is more acute in certain areas including Manchester, Liverpool, Hertfordshire and London. One of the contributing factors in the South East and rural areas is the cost of living.”*

Bupa UK response to MAC call for evidence

- 3.65 Partners have also told us that recruitment budgets vary across the UK. As a result, the supply of nurses is likely to be greater in those regions able to offer a higher salary, whilst those who are unable to do so are likely to be facing a proportionally greater shortage.
- 3.66 The response from the Scottish Government Health Department said that there were difficulties in recruiting nurses to remote and rural locations in Scotland. The Department identified a number of remote and rural Scottish health boards that were experiencing significant recruitment difficulties, namely the Island Boards: NHS Orkney, NHS Shetland, and NHS Western Isles; and parts of other northern and southern boards.
- 3.67 Whilst the MAC did not receive substantial submissions from governing bodies in Wales or Northern Ireland for this review, broader partner evidence from the devolved administrations, although minimal, supported the view that nursing shortages exist and are more prevalent in remote areas.
- 3.68 For the care sector, submissions from partners in Northern Ireland echoed the difficulty in recruiting nurses to rural areas. For example, the Macklin group stated that the care home sector in Northern Ireland had suffered from a nurse shortage for the last 25 years and could only mitigate against this by recruiting staff from inside and outside the EEA. They said that they found it particularly difficult to attract candidates in areas outside of the greater Belfast area.
- 3.69 A Welsh health care provider stated that they were continually struggling to recruit nurses to their nursing home in South Wales, despite extensive

advertising. Scottish Care told us that over two thirds of care providers had experienced difficulty in recruiting nurses over the last year.

- 3.70 In summary, we received evidence stating that there was a shortage of nurses in rural areas, urban areas, large cities and smaller towns and villages, across the UK as well as in England, Scotland, Wales and Northern Ireland. Usually, the evidence said that the shortage pertained to generic nurses but some of the evidence we received did relate to specific nursing specialties. We discuss that evidence in the next section.

### Shortages in nursing specialties

- 3.71 A significant number of the evidence we received, and almost all of the data we looked at, related to the whole of the SOC 2231 nurse occupation. As we have seen, within that occupation there are a number of fields and specialties. We did receive some evidence relating to shortages in these areas as opposed to across the whole of the wider occupation.
- 3.72 We do not include an exhaustive list of all of the specialties that partners told us were in shortage. The evidence we received, of which the instances below are just examples, reflected the views and experience of individual bodies, trusts and other care providers. A number of partners told us that neonatal, mental health, and paediatric intensive care nurses were currently in shortage. However, this was not consistent across all of the evidence that we received.
- 3.73 The Department of Health told us that the following areas were in shortage:
- Adult nurses for health and social care
  - Children's nurses
  - Nurse endoscopists
  - Specialist nurses working in operating theatres
  - Specialist nurses working in neonatal intensive care units
  - Specialist nurses working in paediatric intensive care units
  - Mental health nurses
  - Learning disabilities nurses
- 3.74 HEE identified demand and supply gaps across a number of nurse specialties including neonatal, community and district nurses and health visitors. University Hospitals Birmingham NHS Foundation Trust said that shortages were experienced in critical care provision, theatre nursing, renal dialysis and oncology.

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- 3.75 The Shelford Group Chief Nurses identified the following areas where nurses are most critically in short supply: emergency department, theatre critical care, specialist paediatrics, renal dialysis and general medicine. Monitor told us that there are shortages in nursing specialities such as intensive care, radiology and mental health nurses.
- 3.76 Additionally, evidence received from Bliss, a charity dedicated to premature and sick babies, stated that three quarters of neonatal units had unfilled nursing vacancies, which equated to roughly 650 neonatal vacancies across England. This was supported by evidence we received from the Royal College of Paediatrics and Child Health.
- 3.77 Springhill Care submitted evidence citing research which showed that the care sector was short of 4,000 nurses. In particular, care homes faced difficulty in filling senior nursing and nursing manager roles, which, in some cases, were taking over a year to fill.
- 3.78 Whilst we received evidence suggesting that a number of specialities are in shortage, we are considering the entirety of the SOC code 2231: Nurses, and as such all specialities of nurses will be captured within our recommendations.

## 3.5 Conclusions

- 3.79 Our top-down analysis of the shortage indicators suggest that nurses are currently in shortage nationally across the UK. The vacancy data imply some regional variation in the extent of the shortages, which appear to be most acute in England. However, due to limitations in the data it is difficult to draw firm conclusions on this. The partner evidence we received also suggests that across the NHS, care and independent sectors many employers are struggling to recruit to fill nursing vacancies.
- 3.80 On balance, we consider that there is sufficient data and evidence to reasonably conclude that there is a UK national shortage of nurses across the whole of the SOC 2231 occupation. In the following chapter, we identify the underlying factors that have contributed to this shortage.

## Chapter 4: Demand, supply and pay

### 4.1 Introduction

- 4.1 In Chapter 3, we presented data and partner evidence looking at whether nurses are presently in national shortage across the UK. This chapter looks at the factors underpinning the present demand for, and supply of, nurses in the health and care sectors. We then consider in the next chapter whether retaining nurses on the shortage occupation list (SOL) meets our *sensible* criterion.
- 4.2 We begin by exploring the evidence on the factors contributing to an increased demand for nurses. We then look at the factors affecting the supply of nurses. In the final section of this chapter, we look at trends in nurse pay as a precursor to considering, in the next chapter, whether changes in pay have contributed to the shortage and whether it would significantly affect the supply of nurses.
- 4.3 Partners told us that the demand for nurses over recent years has been affected by a number of factors including:
- *changing demographics* – general growth in the population together with an ageing population has led to a growth in demand for health and care services;
  - *healthcare reform* – the drive towards greater integration of health and social care services has resulted in increased demand for nurses in the care sector. On the other hand, increased constraints on funding and efficiency gains in the health and social care sectors might be expected to have reduced demand in the NHS;
  - *the changing roles of nurses* – nurses were increasingly required to undertake more advanced practices which resulted in them requiring additional training and mentoring while taking them away from other duties; and
  - *a greater focus on quality of care* – the Francis report led to updated safe staffing guidelines which effectively created a demand shock.

## Review of nursing

- 4.4 Partners also highlighted a number of factors which has restricted the supply of nurses in the UK, namely:
- *recruitment* – cuts to training places have reduced the numbers of new nurses entering the profession;
  - *retention* – the challenging working environment has resulted in many nurses choosing to either retire early, move to alternative roles within the health sector, move into other occupations or to work abroad.
- 4.5 Although many partners did not cite pay as a factor in the supply of nurses, and some explicitly said it was not a factor, in the final section of this chapter we review trends in nurses' pay across the NHS, care sector and agencies. We outline the constraints on pay, and consider the competitiveness of UK pay compared to those countries in which UK trained nurses often choose to work.

### 4.2 Demand side factors

#### Population growth and demographic change

- 4.6 Partners told us that part of the increase in demand for nurses in recent years was attributable to the overall increase in the UK population, resulting in health and care services having to treat more people. The latest ONS estimates are that the UK's population was 64.6 million in 2014, an increase of 11.6 per cent (6.7 million) from twenty years ago (ONS, 2015). The ONS predict this will increase by 12.6 per cent to 72.7 million by 2034. Partners have said that further increases in the UK population will result in more hospital admissions.
- 4.7 Separately, an increase in the number of older people has added to the demand for health and care services. We were told that people were living longer and presenting a range of complex needs and multiple conditions which required heightened levels of nursing attention. The sum of the increased numbers presenting themselves for treatment and the greater number of conditions per patient has acted to increase the demand for nurses. This rise in acuity meant that higher ratios of nurses to patients were required to deliver quality care. Partners explained that this affected public and private health care providers as well as the care sector.
- 4.8 ONS population estimates are that in 2014, 8 per cent (5.2 million) of the population were aged 75 or older (ONS, 2015a). This has increased from 6.8 per cent (3.9 million) 20 years earlier and is expected to further increase to 12 per cent (8.7 million) in twenty years time illustrating the potential increase in demand on health and care providers (ONS, 2015b). In absolute terms, the number of people aged 75 or older is therefore expected to increase by 3.5 million between 2014 and 2034.

*“The nursing shortage has been exacerbated not only by the shortage of nurses coming through the education system, but also by the increasing activity, acuity and dependency of patients in recent years and growing pressure on social care services, which demand adjusted levels of staffing, both in terms of quantity and skillset.”*

Shelford Group Chief Nurses response to MAC call for evidence

- 4.9 Bupa told us that the increased demand for home care provision from an older population meant that the shortage of nurses was likely to worsen. Care England said that increases in life expectancy meant that individuals were, typically, requiring care for longer periods, adding to overall demand for nurses.

*“Future demand from an ageing population will mean that care homes with nursing will continue to be needed at the current rate or more. This is even with the policy push to ensure people remain as long as possible in their own homes with community support.”*

Care England response to MAC call for evidence 2014

- 4.10 Many of the factors regarding to population and demographics are longstanding trends which may reasonably have been expected to be factored into workforce planning across the health and care sector. Clearly, having to treat more people impacts on demand for staff and other resources. But it seems to us that this increased demand is eminently predictable. This will be further considered when we look, in the next chapter, at whether it is sensible to recruit nurses from outside of the European Economic Area.

### Healthcare reform

- 4.11 Partners told us that the NHS in England had undergone a number of reforms since 2010 which has impacted on the demand for nurses. There has been a drive for improved integration between the health and care sector resulting in increased demand in the care sector for nurses (National Collaboration for Integrated Care and Support, 2013) (Monitor, 2014). On the other hand, there has been a general focus on efficiencies (see, for example, Lord Carter’s report on operational productivity in NHS providers (Lord Carter of Coles, 2016) in conjunction with a tightening budgetary environment which required providers to think about ways of doing more with less.
- 4.12 The care sector is becoming an increasingly integrated aspect of health care provision. Care England told us that NHS trusts were increasingly looking to the care sector to deliver patient care and recovery rather than the NHS at a lower cost. In some cases, this allowed NHS trusts to discharge patients more quickly into the care sector and to focus NHS

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nurse resource on the immediate care of patients and those whose recovery cannot be cared for outside of the NHS. In other cases, it meant patients were treated and cared for directly in the care sector without being admitted into hospital. The care sector, therefore, needs more nurses to cope with the increased demand for its services.

- 4.13 The Department of Health told us that the move towards seven day working in the NHS was further increasing demand for nursing, a view echoed by several other partners.

*“The nursing workforce is expected to be put under additional pressure as seven day care is rolled out across the NHS with staff numbers, shift patterns and rostering requiring planning in advance”*

Department of Health response to MAC call for evidence

## The changing role of nurses

- 4.14 Some partners told us that the role of nurses has evolved, with nurses increasingly taking on more responsibilities including some duties previously carried out by doctors. NHS England said that this has come about, in part, due to changes in junior doctor training. Junior doctors now spent less time in the delivery of care, particularly in acute care areas.

*“We are seeing an increased demand for nurses in more advanced roles particularly those which were previously undertaken by medical staff... Services are becoming increasingly nurse led as nurses with acute assessment and prescribing skills are undertaking more advanced roles in clinical settings, as prescribers, in triage roles and as advanced nurse practitioners or nurse consultants.”*

NHS England response to MAC call for evidence

- 4.15 We went to visit the Shrewsbury and Telford Hospital NHS Trust who told us that they are participating in a programme whereby the Virginia Mason Institute, a US-based teaching facility, mentors doctors and nurses in five UK trusts to improve the safety and quality of healthcare delivery. One initiative has been to introduce a nurse-led model of operations, giving nurses increased responsibilities over and above their traditional roles.

**Box 4.1 Case study: The Shrewsbury and Telford Hospital NHS Trust**

The MAC visited The Shrewsbury and Telford Hospital NHS Trust, which provides hospital services from two main hospital sites, serving over half a million people from Shropshire, Telford & Wrekin and mid Wales.

The Trust expressed their concern over the current shortage of nurses. As of December 2015, the Trust was operating at a day-to-day 5.2 per cent shortfall in registered nursing and midwifery staff<sup>[1]</sup>. However, without heavy reliance on expensive agency staff, the Trust would instead have a 10 per cent vacancy rate for registered nurses.

Despite repeated attempts to recruit in both the UK and the EU, approximately £8m per year is still being spent on nursing agency staff. Whilst the Trust told us that it is expensive to recruit nurses from outside the EU (up to £3,500 per nurse), the cost of the alternative – hiring agency nurses - is so expensive that this cost is recouped within 12 weeks.

Two main factors have driven the increase in demand for nurses. The first has been the safer staffing review in November 2013, which has led the Trust to have to increase nurse to patient staffing ratios to deliver improvements in the quality of care. The second is a recent partnership with the Virginia Mason Institute to begin the transformation to a more nurse-led model of operating with an increased reliance on the nursing workforce and an objective to increase the time nurses can spend on care. Nurses are increasingly trained to specialise in select roles once solely the responsibility of junior doctors, such as Emergency Nurse Practitioner, Advanced Clinical Practitioner and Endoscopy Nurse. These advanced roles for experienced nurses increase the demand for Band 5 Staff Nurses to ensure all roles are covered.

Recent efforts by Health Education West Midlands to increase the training places for nurses have not been felt in large numbers by the Trust due to their rural location and lack of a teaching hospital within the Trust. The Trust told us that they had developed their own initiatives to improve the supply of nurses, by commissioning nearby universities to train extra nurses outside the normal bursary structure. Alongside a new direct master's programme, these nurses are more likely to stay for a prolonged period at the Trust.

The Trust said that these efforts only go part of the way to addressing the shortage and in the short term, non-EU migrant nurses are required to reduce the current reliance on agency staff until the new nurses are fully trained.

- 4.16 NHS Employers cited the examples of advanced nurse practitioners who were authorised to write prescriptions, and of nurses moving into new areas of work such as the delivery of telephone services like NHS 111. This expansion of the role of nurses has contributed to an increase in demand for nurses.

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<sup>[1]</sup> [http://www.sath.nhs.uk/Library/Documents/Safe\\_Staffing/1512-Staffinglevel.pdf](http://www.sath.nhs.uk/Library/Documents/Safe_Staffing/1512-Staffinglevel.pdf)

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*“...development of advanced roles provides excellent opportunities for nurses to work outside traditional nursing roles, but does reduce number of nurses providing direct nursing care to patients and families.”*

Central Manchester University Hospitals NHS Foundation Trust response to MAC call for evidence

- 4.17 As with the increases in the population, the NHS cannot claim that changes to the role of nurses is an unexpected, unforeseen problem. The impetus for these changes comes from the decisions of those in charge of workforce planning. The drive to have more of what was previously a doctor's role done by a nurse is a long-term trend rather than a recent supply side factor reducing the pool of nurses.
- 4.18 On the other hand, partners told us that other duties previously carried out by nurses were now being done by other staff such as physiotherapists and healthcare assistants. The new role of nursing associates will also take on some of the work currently done by nurses. It is therefore not clear to what extent the changing role of nurses is contributing to overall demand for nurses.

### The Francis report and safe staffing guidelines

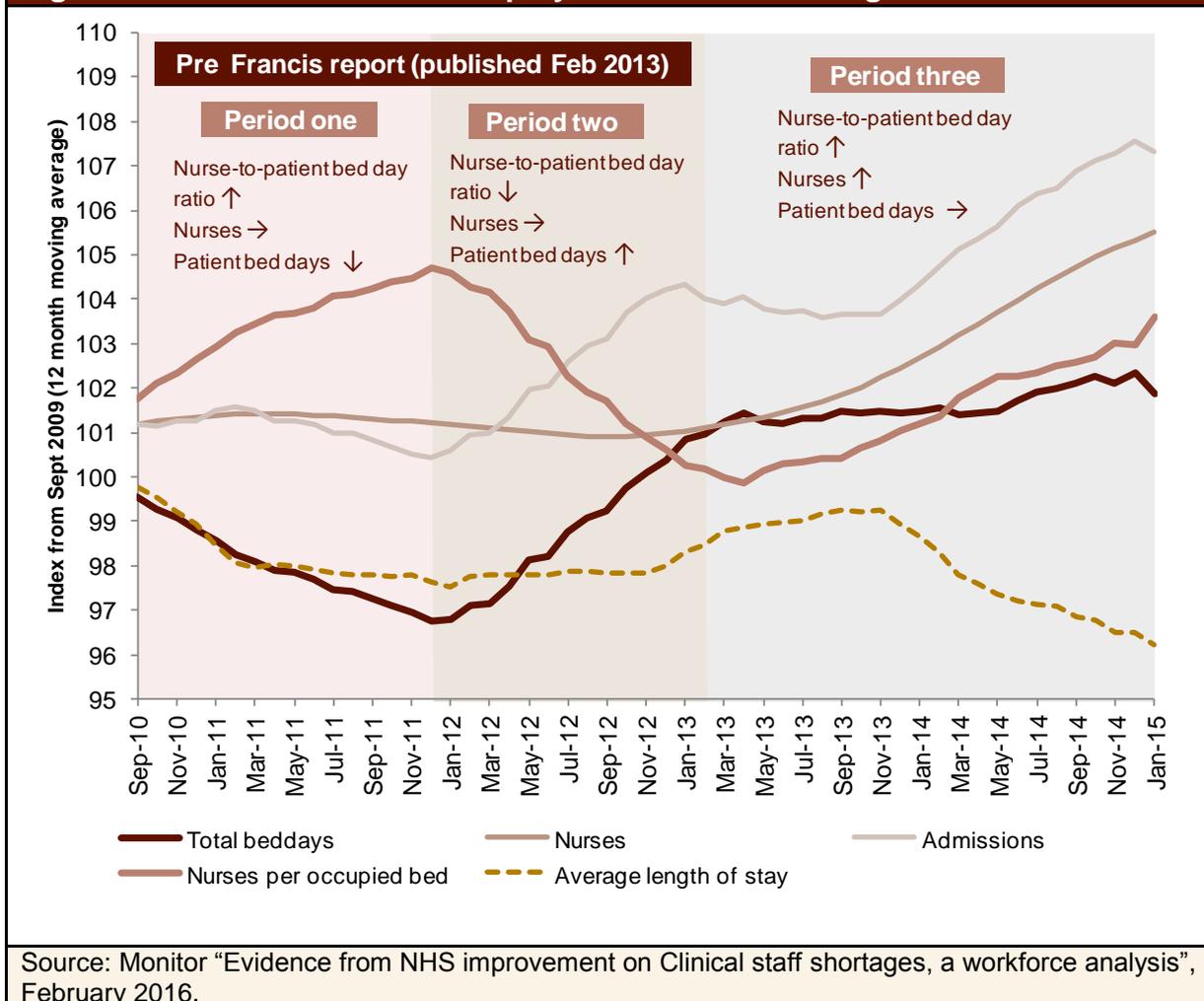
- 4.19 We often heard in our engagement with partners that they had experienced an increase in demand for nurses because NHS trusts were seeking to increase their nurse-to-patient ratios in response to the 2013 Francis report into the events at Mid-Staffordshire NHS trust. In response, the National Institute of Health and Care Excellence (NICE) produced guidance on safe staffing levels. The NICE guidelines did not stipulate a nurse-to-patient ratio but did say that there was evidence of an increased risk of harm when one nurse was responsible for caring for more than eight patients during daytime shifts (National Institute for Health and Care Excellence, 2014).
- 4.20 In a report on the supply of clinical staff in the NHS in England, the National Audit Office (NAO) said that the NICE safe staffing guidelines were not well understood by all parties and that the overall impact on demand arising from these guidelines was difficult to ascertain (National Audit Office, 2016). NAO suggested that the increase in demand for nurses appeared to manifest itself most predominately in the use of temporary staff, but that the overall impact on demand was difficult to ascertain. Furthermore, NAO said that NICE had not considered how staffing levels could be achieved in a timescale that took account of the available supply of staff. A recent report by NHS Improvement (NHS Improvement, 2016) stated that labour supply implications will be considered when assessing future changes to safe staffing guidelines.

*“The conclusions of the Francis Review and consequential safe staffing agenda, which drew strong parallels between patient safety and the numbers of nursing staff, has increased what is considered an acceptable volume of nurse staffing within organisations in a way that does not mirror the number of university places commissioned, thus rendering a national shortage.”*

Shelford Group Chief Nurses response to MAC call for evidence

- 4.21 NHS Improvement recently published a report which looked into the impact of the Francis Report. They found that, between April 2012 and February 2013, the number of hospital admissions and the average length stay increased without any corresponding increase in the average number of nurses, placing more pressure on health care services (NHS Improvement, 2016). Figure 4.1 shows that since March 2013, the average number of nurses employed in the NHS in England significantly increased to partly meet the increase in admissions. In addition, the NHS in England increased its expenditure on agency staff as a proportion of total staff spend (NHS Improvement, 2016).

Figure 4.1: Growth in nurses employed in the NHS in England.



4.22 The evidence indicating a post-Francis increase in demand for nurses is patchy. There is no new requirement on trusts to increase their nursing staff as a result of Francis. At many of our meetings with partners we received a mixed response on the impact of the Francis report with some reducing the nurse to patient ratio and others not being able to give examples. National Audit Office (2016) made the point that it is difficult to separate out the impact of Francis from the other demand factors described in this chapter.

4.23 In November 2015 the MAC commissioned the Institute for Employment Studies (IES) to explore the labour market for nurses in the UK and specifically the demand for, and supply of, foreign-born workers in the NHS in England. The key findings are summarised in Box 4.2.

### Box 4.2: Institute for Employment Studies research

The IES interviewed a range of industry experts and trusts, including those who have recruited few non-EEA migrants and those who have been among the biggest recruiters of non-EEA migrants in recent years. The interviews aimed to ascertain the reasons why some trusts recruit more foreign-born nurses compared to others. The key findings include:

- A trust's recruitment of non-EEA nurses is to some extent dependent on the trust's previous experience of overseas recruitment. Some trusts reported successful positive recruitment campaigns which they have repeated in subsequent years. Other trusts recognised the high upfront cost and the need for a package of support for non-EEA nurses and therefore did not recruit from these areas. Some trusts focused their overseas recruitment on EEA campaigns only.
- Trusts that conduct large, one-off recruitment campaigns in countries such as the Philippines and India are able to retain these nurses for relatively long periods, as it is not easy for them to relocate to competing trusts. Therefore the demand for non-EEA nurses among some trusts can be sporadic.
- Large, acute teaching trusts based in urban centres can offer greater educational opportunities and specialism meaning they are able to attract more domestic nurses. In comparison, neighbouring trusts can struggle to attract nurses to the same degree and are therefore more likely to resort to recruiting more non-EEA nurses.

The researchers also put together a dataset combining trust level data on the nursing workforce (headcount, proportion who are migrant nurses), performance (e.g., staff engagement, turnover and work pressure), financial performance (for foundation trusts only) as well as data on care quality ratings across trusts, and local economic and demographic characteristics. The aim was to identify quantitatively whether there was any consistent relationship between the recruitment of non-EEA nurses and trust level characteristics. Key findings of this quantitative analysis include:

- In general, the analysis did not identify any clear or consistent relationship between trust level characteristics and usage of non-EEA nurses.
- In some model specifications, a lower unemployment rate in a trust's catchment area and the need for staff to work more extra hours, were associated with a greater proportion of non-EEA nurses in the trust's workforce. There was also limited evidence that changes in the proportion of non-EEA nurses were linked to local labour market conditions.
- There is large regional variance in the demand for non-EEA nurses. Trusts in London and the South East have significantly higher usage of non-EEA nurses than that elsewhere in England.
- We expect to publish separately the full findings from this research in spring 2016.

Source: Institute for Employment Studies research report, commissioned by the Migration Advisory Committee (publication forthcoming).

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### 4.3 Supply side factors

- 4.24 Qualified nurses now need to have a degree in the subject area to work in the profession. Health Education England controls the supply of nurses in that they fund the training places. Applications exceed available training places. However, if significant numbers of nurses decide to leave the profession, this will also impact on the supply. In this section, we examine how workforce planning, commissioning of training places and constrained recruitment of migrant nurses has reduced the available supply of nurses. We also look at how turnover, an ageing workforce, retirement and emigration of UK nurses has impacted on employers' ability to retain nurses.

#### Recruitment

##### *Workforce planning*

- 4.25 As described in Chapter 2, Health Education England (HEE) are responsible for funding training places for nurses in England using money they are allocated by the Government. The non-NHS employers of nurses (predominantly, nursing and care homes, private healthcare providers and nursing agencies) do not contribute funding directly to nurse training places and, until recently, do not appear to figure in HEE's nursing workforce planning. Although HEE now aim to take account of demand in the care and independent health sectors in their workforce planning, they describe their role as ensuring that the supply of nurses through the training pipeline is adequate to meet future health care demand primarily in the NHS, rather than across the health and care sectors, for instance.

*“Health Education England is responsible for ensuring that there is sufficient future supply of staff to meet the workforce requirements of the English health system. In undertaking this role it must also work with partners to assess, but not have primary responsibility for, the workforce consequences for the wider health and care system.”*

Health Education England commissioning and investment plan 2015-16

- 4.26 A number of partners including the Royal College of Nursing, UNISON, Four Seasons Healthcare, the Shelford Group and other independent healthcare providers stated that, in their view, the approach to workforce planning across the health and care sectors was not fit for purpose and required comprehensive review.

*“Workforce planning process in the NHS is based on employer forecasts, which do not take into account workforce needs from independent and social care or the voluntary sector. Despite central workforce intelligence showing that demand for nurses will not meet supply, commissions have been reduced resulting in current pressures with no foreseeable solution despite commissions being increased in 2015. These students will take 3 years to complete the training programme.”*

Central Manchester University Hospitals NHS Foundation Trust response to MAC call for evidence

- 4.27 The NAO review of managing the supply of NHS clinical staff in England (NAO, 2016) concurs with what many partners said to us. The NAO concluded that the managing arrangements were fragmented and did not deliver value for money. They acknowledged that the creation of HEE has provided some central oversight, but that HEE plans remained essentially locally driven, with trusts providing localised forecasts of demand.
- 4.28 The NHS Trust Development Authority and Monitor set efficiency targets requiring trusts to make significant financial savings. The NAO reported how between 2012-13 and 2015-16, trusts planned to make aggregate recurrent pay savings of around £1 billion each year, although actual savings consistently fell well short of this amount (NAO, 2016). By focusing on efficiency targets when balancing financial sustainability and service requirements, trusts risk understating their true staff needs and HEE commissioning too few places to train new staff (NAO, 2016). At a trust level, it may also lead to gaps in staffing or additional costs from using more expensive temporary staff to address a shortfall. The NAO concluded that these individual trust workforce plans are motivated as much by meeting efficiency targets as meeting staffing targets.
- 4.29 This last point was echoed by several other partners who felt that decisions such as the reduction in the number of training places had been motivated by financial concerns rather than effective workforce planning.

*“Central workforce modelling suggests that demand for nurses will outstrip supply but often workforce planning returns have demonstrated reduction in commissions and this is felt to be based on financial affordability and often unachieved local assumptions about reductions in service/changes to service delivery which do not then demonstrate workforce efficiencies.”*

University Hospitals Birmingham NHS Foundation Trust response to MAC call for evidence

- 4.30 The current HEE system for workforce planning involves aggregating local workforce plans into a national plan for England. The NAO said that this overlooks systematic changes in how services are delivered and

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suggested that a more co-ordinated and proactive approach to managing the supply of staff could result in efficiencies for the NHS as a whole.

- 4.31 We stated above that non-NHS employers do not generally directly contribute to the cost of training nurses. They are, however, reliant on a supply of nurses from somewhere, whether from within the UK or the EEA or outside of the EEA. Agencies, meanwhile, according to the evidence we received, recruit many of their nurse staff from within the NHS and the care sector. The care sector, in turn, told us that they lost many of their nursing staff primarily to the NHS. The NHS, care and independent sectors and nursing agencies are in competition with each other for the available nursing supply.

*“We are working with Social Care colleagues to ensure that we include their baseline staffing levels and demand forecasts in our national workforce planning cycles (to support education commissioning) and we are beginning work with the independent sector to replicate this analysis.”*

Health Education England response to MAC call for evidence

- 4.32 In fact, there is a structural undersupply of nurses in the UK that has been caused by the failure to factor demand from non-NHS employers into workforce planning. Our discussion here has focussed on workforce planning in England, but the evidence we received suggested that similar issues and concerns also applied to planning in Scotland, Wales and Northern Ireland.

*“The deficit in skilled labour is due to a lack of workforce planning by the Department of Health in Northern Ireland as they have failed to include the Qualified nurses working in the independent, community and voluntary sectors in Northern Ireland into their workforce planning”*

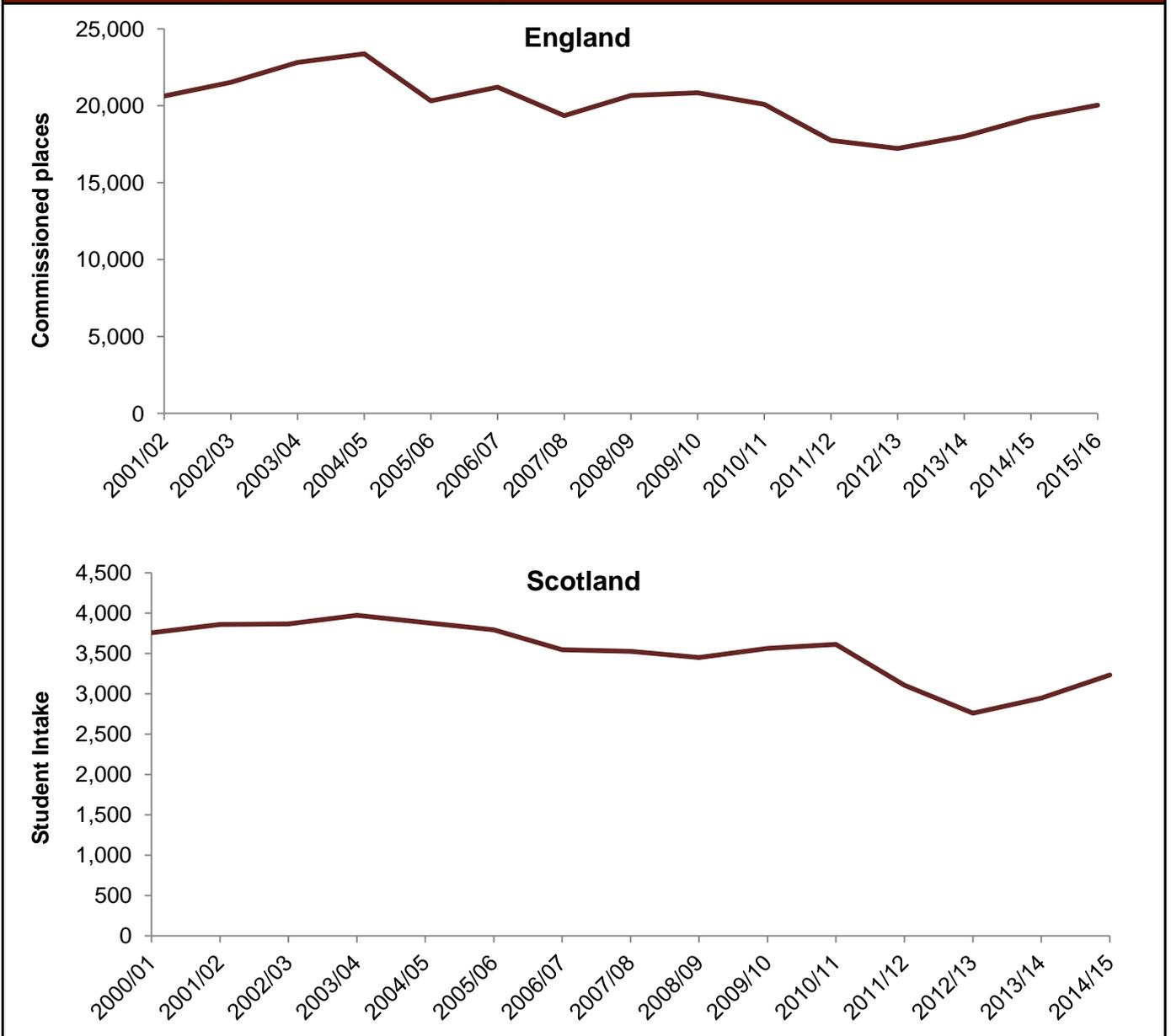
The Macklin Group response to MAC call for evidence

### *Training commissions*

- 4.33 Looking at the UK as a whole, the total number of nursing places commissioned was around 26,400 in 2009-2010. This declined significantly by 18 per cent (4,800) to around 21,600 places in 2012-2013.
- 4.34 The Royal College of Nursing (RCN) published a review of the nursing labour market (Royal College of Nursing, 2015a) which showed that the number of nurse training places commissioned in England has reduced by 17 per cent, from around 20,800 in 2009-2010 to around 17,200 in 2012-2013. However, since then the number of training places commissioned in England has increased to 20,000 in 2015-2016.

4.35 HEE have acknowledged that they would have recommended substantially higher numbers of additional training places for nurses in 2016-2017 in the absence of financial pressures. We were told that HEE has acknowledged that, on the basis of workforce modelling alone, they would have liked to commission an additional 3,000 places in 2016-2017. Funding constraints meant that they had only commissioned an additional 331 places; one tenth of what was actually needed (HEE, 2015).

**Box 4.3: Training commissions in England and student intakes in Scotland.**



Source: Higher Education England (2015) NHS Scotland (2015)

4.36 In Scotland, there was a 23 per cent reduction in intake for nursing courses, from around 3,500 in 2009-10 to 2,800 in 2012-13.

4.37 In Wales, the number of nursing places commissioned was reduced by 34 per cent, from 1,200 in 2009-10 to 900 in 2012-13. Since then, the number of training places commissioned has increased by 34 per cent to 1,300 in

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2015-16 (RCN, 2015a). over the same period, there was a 12.5 per cent reduction in the number of training places commissioned in Northern Ireland, down from around 800 in 2009-10 to 700 in 2014-15. There were no planned training place increases in 2015-16 in Northern Ireland (RCN, 2015a).

- 4.38 It seems self-evident to us that the reduction in the number of commissioned training places between 2010 and 2013 across England, Scotland, Wales and Northern Ireland, was a significant contributing factor towards the current national shortage of nurses. There has been no diminution in demand for nurses and, as a result, many employers found themselves competing with other trusts, agencies and care homes for the same nurses.

*“The most significant contributing cause to the shortage of nursing numbers in recent years is the reduction in the number of commissioned places for nurse training, which in turn has resulted in fewer nurses qualifying thus reducing the supply of nursing staff available to the NHS.”*

Shelford Group Chief Nurses response to MAC call for evidence

- 4.39 Although nurse training commissions have now largely returned to 2010 levels (apart from in Northern Ireland), there has been no increase in places to make up the shortfall that occurred between then and now. The Shelford Group told us that the reduction in commissioned training places has had a particularly negative impact on the supply of specialist nurses as these required an additional two to three years training. Overall, partners told us that the supply of UK trained nurses remained insufficient to meet current demand.
- 4.40 In the 2015 Spending review and Autumn Statement (HM Treasury, 2015), the Government announced that it will look to end bursaries for nursing degrees. Degrees will become self-funding with undergraduates accruing debt to pay for the course. Because the Government will no longer be directly funding nursing degrees, it is anticipated that there will be no restrictions placed on the number of courses or number of places on courses that each degree awarding body can offer.
- 4.41 Partner evidence was mixed as to the impact of removing bursaries on the supply of nurses. Some recognised the possibility of more training places being available. Others were concerned that fear of incurring debt would put students off applying for courses, or would lead them to apply for other courses which might offer greater returns in terms of future salaries. Others pointed to the non-completion rates of nursing courses and postulated whether a drop in quantity might be matched or bettered by an increase in quality, in that the non-availability of a bursary might act to siphon off those students without a real commitment to the nursing profession. We return to the issue of bursaries in Chapter 5.

- 4.42 Although HEE are primarily responsible for commissioning nurse training places in England, some NHS trusts take it upon themselves to provide training places to ensure workforce supply meets demand. Evidence submitted by NHS Employers showed that of the 147 trusts they surveyed, 34 (23 per cent) pursued non-commissioned training.
- 4.43 The Registered Nursing Home Association told us that, in future, there will be more scope for independent care providers to sponsor individuals through a career path resulting in qualification as a registered nurse.

*“Historically Adult Social Care has had no control, and very little input, to the numbers of commissioned places within nurse education...Adult social care employers, in future, will be able to encourage, and sponsor individuals through the new career path from care certificate to apprentice, to nursing associate, further apprenticeship or foundation degree and finally to a nursing degree.”*

Registered Nursing Home Association response to MAC call for evidence

### *Constrained recruitment of migrant nurses*

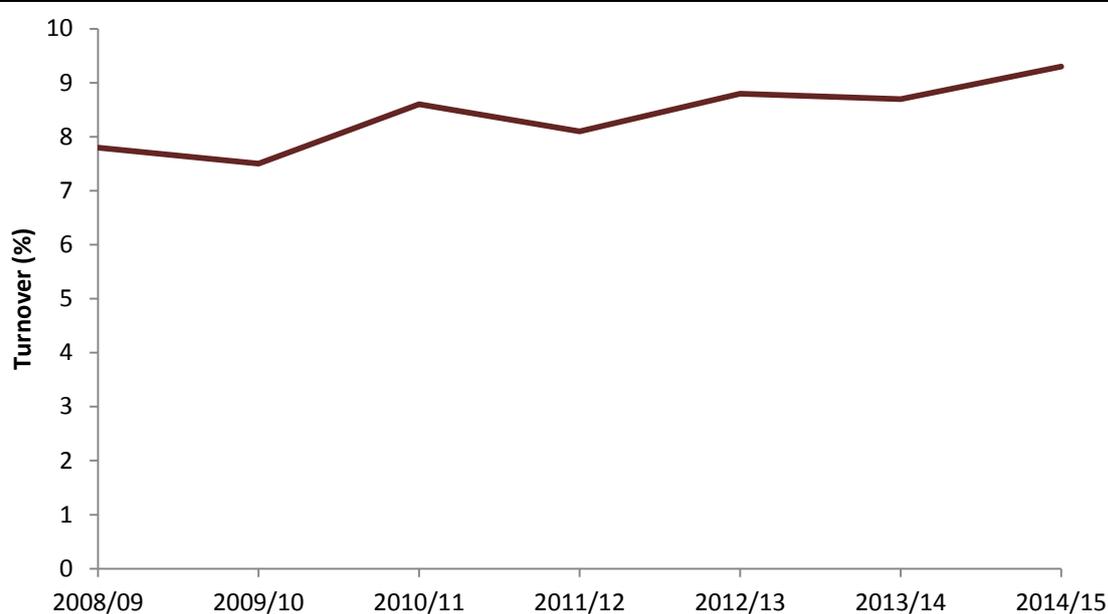
- 4.44 In Chapter 2, we described how employers have recruited more nurses from within the EEA in the last five years including countries such as Italy, Spain and Portugal. However, partners told us that the supply of EEA nurses was drying up and that the standard of recruits was no longer as good as in previous years. Partners were concerned that the standard of English language skill possessed by these EEA recruits was insufficient to pass the International English Language Test System level 7, rendering them unable to work as nurses in the UK. We were also told that EEA nurses tended not to stay with any one employer for a significant period. We consider EEA nurse recruitment in more detail in Chapter 5.
- 4.45 In addition, the supply of non-EEA migrant nurses in 2015 was constrained by the Tier 2 (General) limit on skilled immigration. There is an annual limit, allocated on a monthly basis, on the number of certificates of sponsorship (CoS) that can be issued for Tier 2 migration and each month from June to October in 2015 that limit was reached. Preference is given to occupations on the shortage occupation list (SOL) and to PhD level occupations, and any remaining CoS are allocated by salary from the highest down. Our analysis in our recent Tier 2 report showed that employers seeking to recruit nurses were among the biggest losers of this limited allocation. The inclusion of nurses on the SOL means that employers benefit from them being in the preferential group should the Tier 2 limit be reached again.

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### *Retention*

- 4.46 Any consideration of the nursing labour supply needs to take account of retention of nurses: the net growth of the nursing workforce depends on the difference between the numbers of new entrants to the profession and the numbers of those exiting. Any shortfall in that workforce may not just be due to insufficient numbers of training places but may also be caused, or exacerbated, by a failure to retain existing staff.
- 4.47 The Department for Health provided us with data which showed that turnover, calculated by dividing the number of leavers by the average of the headcount of staff at beginning of the period and headcount of staff at the end of the period, for nurses working in the NHS has increased from 7.8 per cent in 2008-2009 to 9.3 per cent in 2014-2015.

**Figure 4.2. Trends in turnover of nurses in the NHS (England)**



Source: Department of Health (2015)

- 4.48 NHS partners acknowledged to us that good retention policies were an integral aspect of delivering a stable workforce. For example, Health Education England said that one of the key aspects for achieving self-sufficiency in the NHS in England was improving retention.
- 4.49 Table 4.1 shows the rate at which qualified nurses and midwives are leaving the NHS in England. Rates of joining and leaving have both risen in recent years and this probably reflects the more buoyant labour market following the 2008 recession. Since 2011-12 there has been a reversal in the trend for net recruitment. Initially there was a net loss of around 3,500 nurses in the two years to 2012-13. But since then the picture has been more positive, with net inflows of almost 9,000 nurses since 2012-13.

**Table 4.1: Qualified nurses and midwives joining and leaving the NHS, 2011/12 to 2014/15.**

Year	Leavers	Leaving Rate	Joiners	Joining Rate	Difference
2011/12	26,916	7.7%	23,688	6.7%	- 3,228
2012/13	27,511	7.9%	27,240	7.8%	- 271
2013/14	28,907	8.2%	33,924	9.7%	5,017
2014/15	30,655	8.6%	34,617	9.7%	3,962

Source: Health Education England. "HEE Commissioning and Investment Plan 2016-17"

Notes: Leavers also reflect staff moving from the NHS to agency employment.

- 4.50 However, NHS Employers told us that improved retention, return to practice programmes and increased nurse training commissions would not alone be sufficient to alleviate current supply pressures.

*"Retention is complex and the reasons why people may choose to stay or leave a role can be largely personal and driven by a range of personal factors. Clearly, ensuring individuals are recruited into a suitable role, that they are supported, have clear objectives, feel valued and suitably rewarded for the role is critical."*

NHS Employers response to MAC call for evidence

- 4.51 We now look at what we were told about some of the reasons why nurses leave the profession.

*Working conditions*

- 4.52 The Department of Health told us that working conditions were a primary driver of current concerns about retention in the nursing profession.

*"A major issue in the retention of nurses relates to the overall working conditions and poor image associated with the profession. The organisations that nurses work in are seen as becoming less stable in terms of their structures and leadership, leading to a poor working environment. Nurse to patient ratios are reducing due to recruitment issues, leading to increased stress and fatigue levels among nurses. This may encourage nurses to move to different roles or to reduce their hours. Other issues include the high proportion of nurses at retirement age and, as nursing is a predominantly female workforce, a significant proportion leave or reduce their hours to look after children or become carers."*

Department of Health response to MAC call for evidence

- 4.53 HEE investigated the reasons why nurses left the profession and reported the common factors as: stress and burnout; lack of job satisfaction; and work environment (HEE, 2014). Turnover rates were found to be highest

## Review of nursing

for nurses working in inner cities, in certain nursing occupations such as mental health, critical care and elderly care, and for newly qualified nurses.

*“We gathered some anecdotal information as part of our Call for Evidence that the introduction of new working practices (such as new shift patterns) had a negative effect on retention of staff.”*

Health Education England response to MAC call for evidence

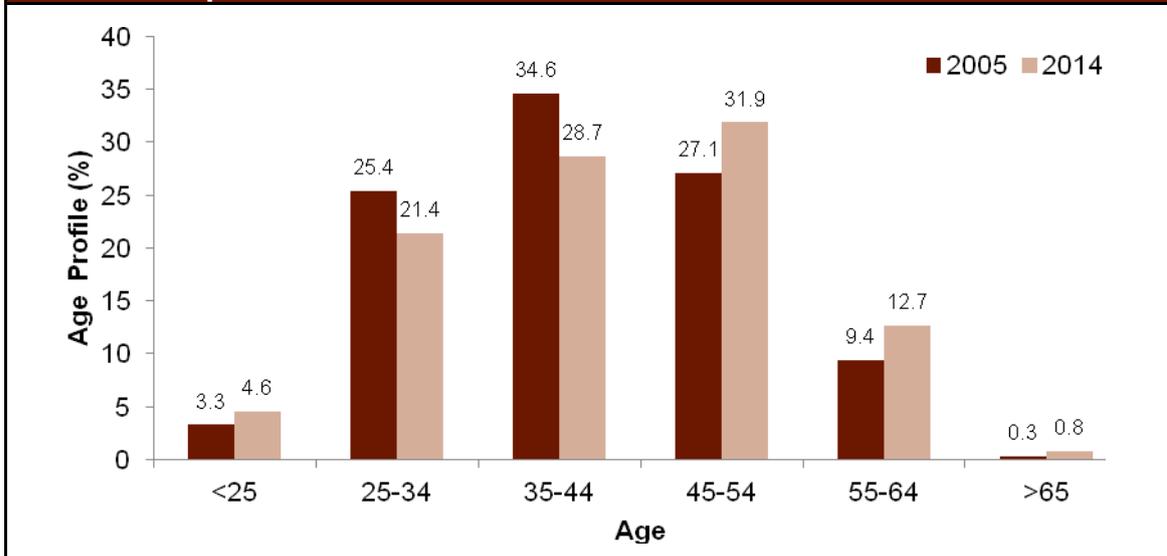
- 4.54 In response to our call for evidence, HCL Workforce Solutions, a health care recruitment agency, carried out a survey on a sample of their locum staff. When asked why they thought there was a nursing shortage the vast majority of respondents cited pay, lack of flexibility, mismanagement, low morale and staff feeling overworked and undervalued. When asked what would encourage them to return to a permanent nursing post, 26 per cent of respondents listed increased flexibility. Responses included: *“Ability to choose when I work to fit around my family”*; *“Good working conditions and a flexible rota”*; *“Less rigidity of work and booking annual leave”*; and *“More flexible working hours, and not to be told that my childcare is not their problem”* (HCL Workforce Solutions response to MAC call for evidence).
- 4.55 We were told, both in the written evidence we received and at meetings, that uncertainty over shift patterns and rostering arrangements were a significant factor in nurse dissatisfaction with their job.
- 4.56 Given the importance current and former NHS nurses attach to flexible working, it is surprising that a number of detailed questions on this issue were dropped from the annual NHS staff survey after 2011. These covered areas such as flexi-time, job-sharing, term-time working, working reduced or annualised hours, team autonomy over rota decisions and whether employers/managers help staff find a good work-life balance and are open to conversations about flexible working (NHS Staff Survey 2003-2014). However, one question on the opportunities for flexible working has since been added to the 2015 survey. The (unweighted) data suggest that over half (57 per cent) of nurses across all NHS organisations in England were either satisfied or very satisfied with such opportunities, though it is slightly lower (50 per cent) among those working in acute trusts.

### *Retirement*

- 4.57 Partners identified an ageing workforce as a key factor reducing the existing supply of nurses. As shown in Figure 4.3, between 2005 and 2014, the proportion of nurses aged 45 and above increased. In particular, the proportion of nurses aged between 55 and 64 increased from 9.4 per cent to 12.7 per cent. A significant proportion of nurses were, therefore, at or near the earliest age at which they could retire. Many chose to do so

and this was not offset by an increase in numbers by newly qualified or mid-career nurses.

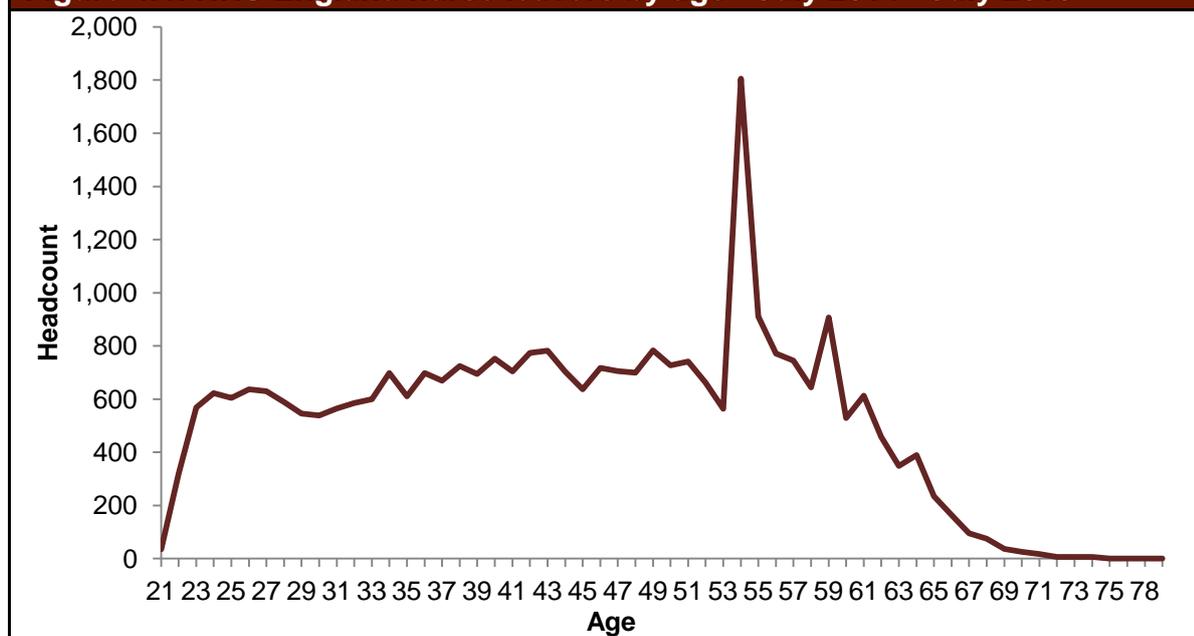
**Figure 4.3: NHS England, age profile, qualified nursing staff, September 2005 and September 2014**



Source: Royal College of Nurses Labour Market 2015 report. Data from Health and Social Care Information Centre (HSCIC).

- 4.58 Evidence submitted to us by Monitor identified changes to the NHS pension scheme, reducing the minimum age nurses can apply for retirement, as having incentivised nurses in large numbers to take early retirement. Evidence from the Department of Health showed a peak in the number of nurses leaving NHS England at age 55 which aligns with the earliest age at which a nurse can retire on full or part NHS pension benefits.

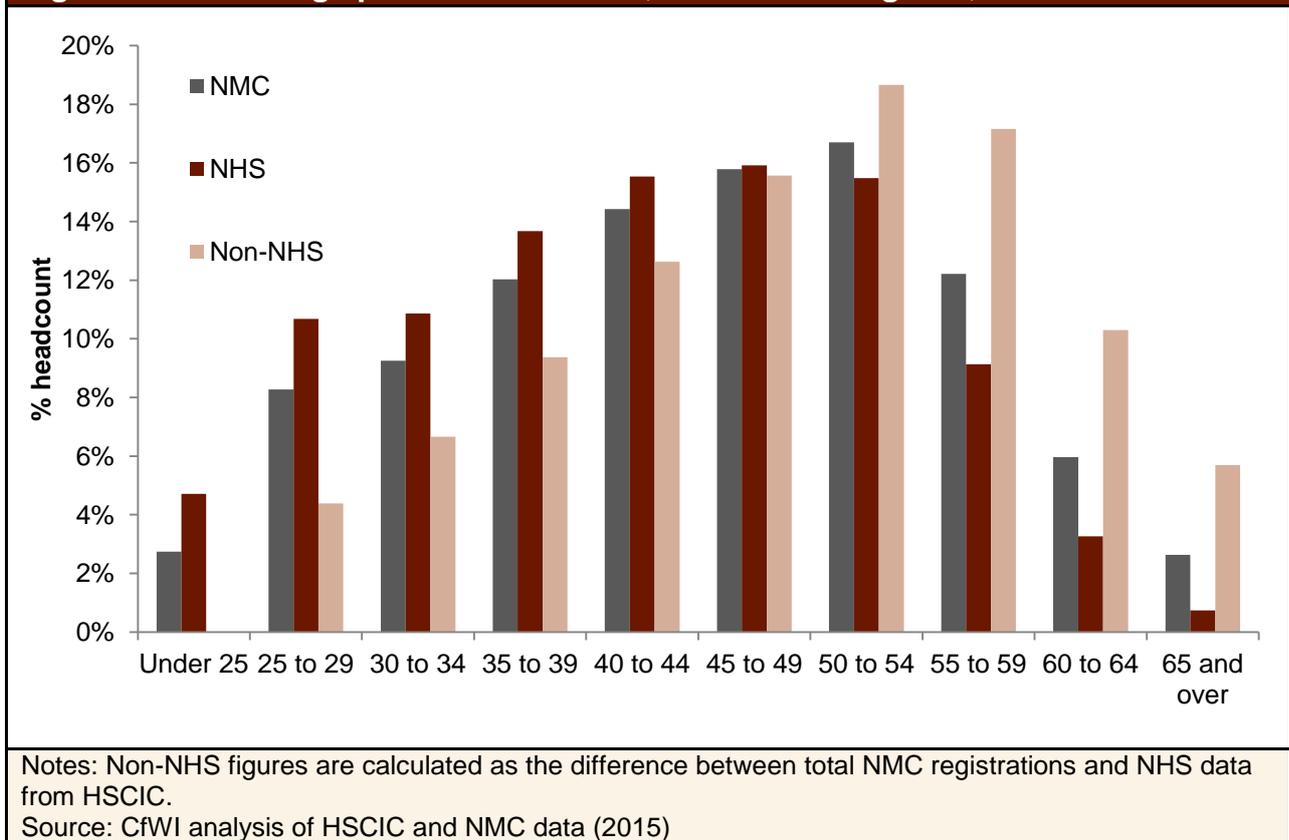
**Figure 4.4: NHS England nurse leavers by age - July 2014 - July 2015**



Source: Department of Health using HSCIC data

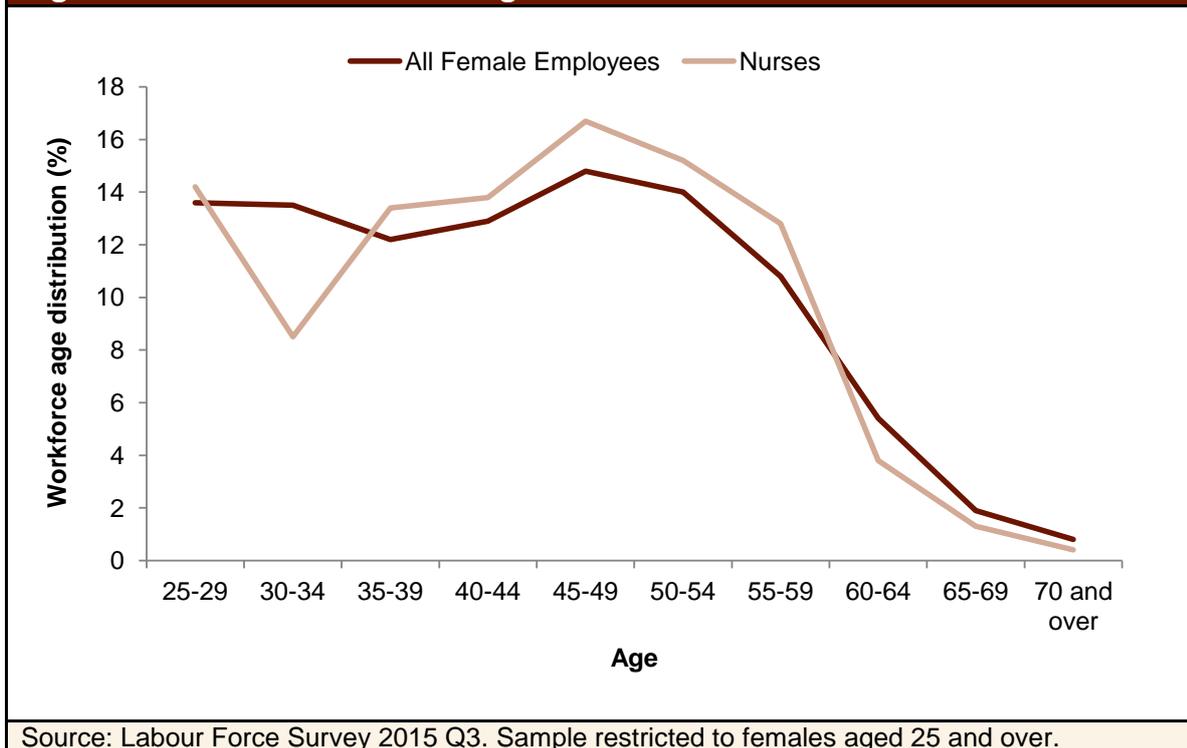
- 4.59 The ageing workforce issue was also raised by the RCN. They told us that 29 per cent of the total nursing workforce in England were over 50, based on data from the Health and Social Care Information Centre (HSCIC), a non-departmental public body sponsored by the Department of Health and providing information, data and IT systems for the health and care sectors.
  
- 4.60 The ageing workforce is particularly an issue in the care sector. Skills for Care stated that 44 per cent of adult social care nurses were aged over 50 (Skills for Care, 2015b). This was corroborated by evidence submitted by the Department of Health which showed that the age profile for non-NHS employed registered nurses was older than that for nurses employed in the NHS, with a particular difference becoming noticeable above the age of 55. The Department said that this was due to nurses retiring from the NHS and taking up work with non-NHS employers such as agencies. The view that NHS nurses were retiring at 55 was also repeated by employers at several meetings.

Figure 4.5: Nurse age profiles in the NHS, on the NMC register, and non-NHS



4.61 To verify the extent to which the ageing workforce was a particular issue in nursing, we used the Labour Force Survey to compare the age profile of the nursing workforce with the UK workforce more generally. As a large majority of nurses are female, we compare the age profile of female nurses against the age profile of all female employees. There is some evidence that a greater proportion of the nursing workforce is aged between 35 and 59 than in the UK workforce as a whole. Figure 4.6 shows 71.9 per cent of the nursing workforce is aged between 35 and 60, compared to 64.7 per cent of the female UK workforce as a whole. Furthermore, it shows noticeably fewer nurses aged 30 to 34 compared to other occupations. This may indicate that nurses have less work flexibility and therefore leave the profession, perhaps in order to start a family, compared to other professions.

Figure 4.6: Female Workforce age distribution

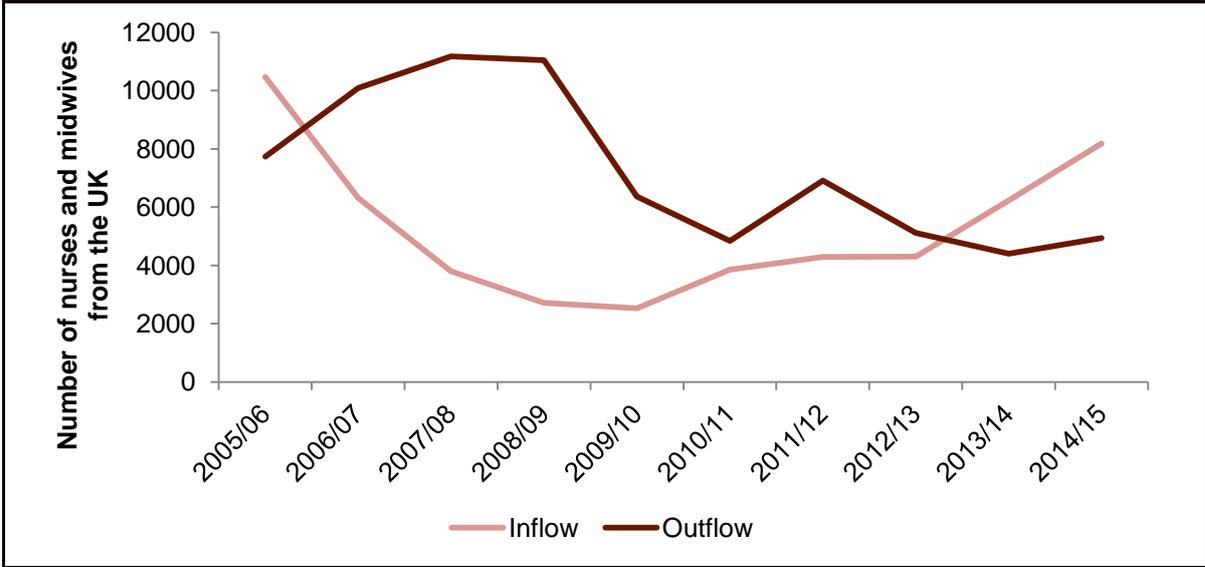


### Emigration

- 4.62 Another area where the UK risks losing its supply of qualified nurses is through emigration. The Department of Health expressed to us a concern that other countries, such as Australia, Canada, Ireland and the US, had indicated they were suffering from an imminent shortage of nurses and that this could lead to these countries targeting increased recruitment of UK nurses.
- 4.63 The Nursing and Midwifery Council (NMC) record the number of registered nurses that choose to work as nurses outside of the UK, based on requests for verification received from nursing regulators in destination countries. According to NMC data, the current top three destination countries for UK émigré nurses are Australia, the United States of America and Ireland. Between 2006-2007 and 2010-11 there was a 52 per cent decrease in verification requests, from 10,085 to 4,842. Outflows in 2014-15 stood at 4,935, a similar level to in 2010-11 (Figure 4.7).
- 4.64 A comparison of NMC data on outflows of nurses from the UK against the NMC data on inflows of nurses onto the register from overseas showed that, for most of the last decade, there has been a net outflow from the NMC register. At its peak, net outflow of nurses reached around 8,300 in 2008/09. As described above, outflows slowed considerably after 2008-09, before finally achieving net inflows, for the first time since 2005-06, in 2013-14. Data for 2013-14, and 2014-15 showed net inflows of 1,800 and 3,200 respectively (Royal College of Nursing, 2015a).

4.65 The trend in the net international flows of nurses essentially mirrors the recent movement of nurses joining and leaving the NHS seen in Table 4.1. The net outflow of nurses from the UK from 2011-2012 will have contributed to the net outflow of nurses working in the NHS. Similarly, the net inflow of nurses into the UK from 2012-2013 onwards will, in part, contribute to the current higher joining rate of nurses in the NHS. The current net inflow of nurses shown in Figure 4.7 has the potential to reverse and boost the stock of nurses.

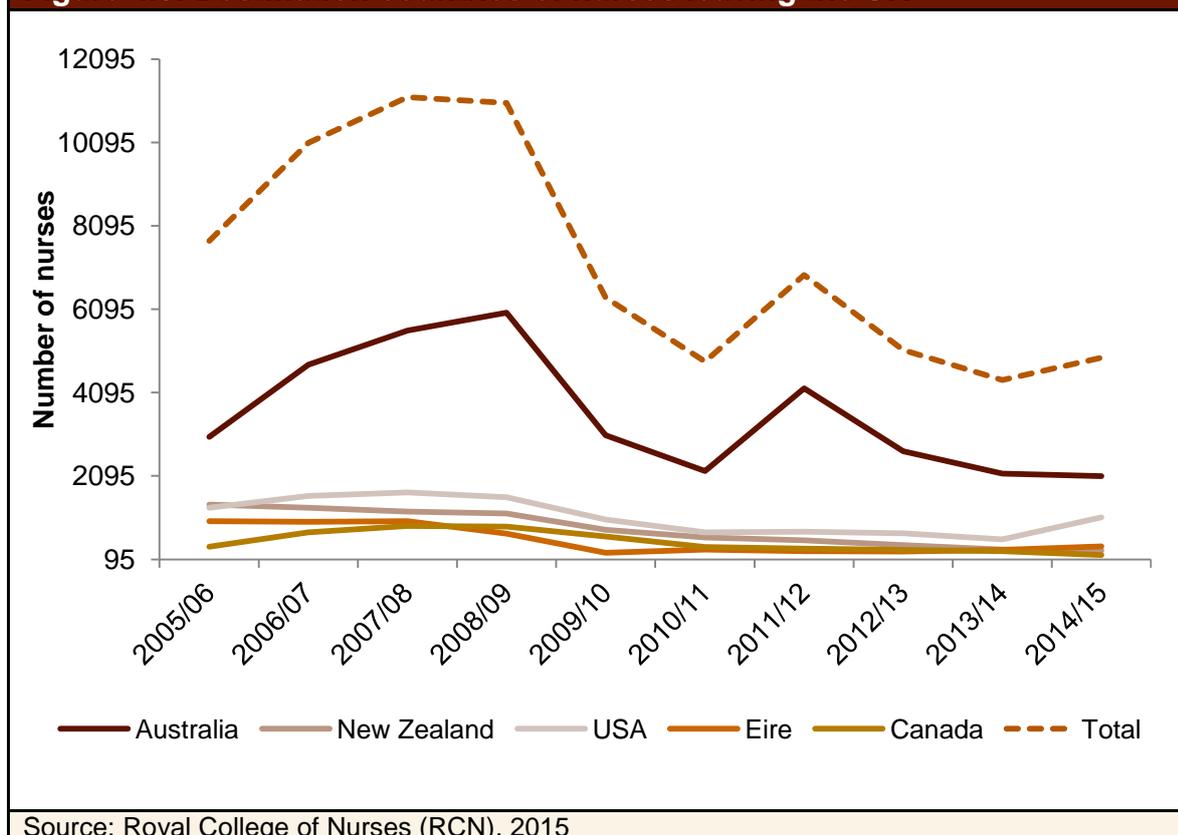
**Figure 4.7: Inflow and outflow of nurses and midwives into and out of the UK, 2005/06 to 2014/15**



Source: Royal College of Nurses (RCN), 2015.

4.66 Figure 4.8 shows the destination countries of nurses leaving the UK (that is, the countries whence the nursing qualification verification request originated). In 2014-15, of the 4,935 requests, 42 per cent were from Australia, 22 per cent from the USA, eight per cent from Ireland, 6 per cent from New Zealand and 4 per cent from Canada, with the remaining 17 per cent from other countries.

**Figure 4.8: Destination countries of nurses leaving the UK**



4.67 Partners told us that UK nurses were incentivised to work abroad by higher pay, greater career opportunities and relocation grants. We examine the impact of pay on recruitment and retention in the next section, and again in Chapter 5.

### 4.4 Nurses' pay

4.68 One of the indicators we use to consider whether an occupation is in shortage is pay. In a market operating freely, wages should adjust to correct any imbalance between demand and supply of labour. In the case of a shortage, we would expect market pressure to force up wages, helping to restore labour market equilibrium.

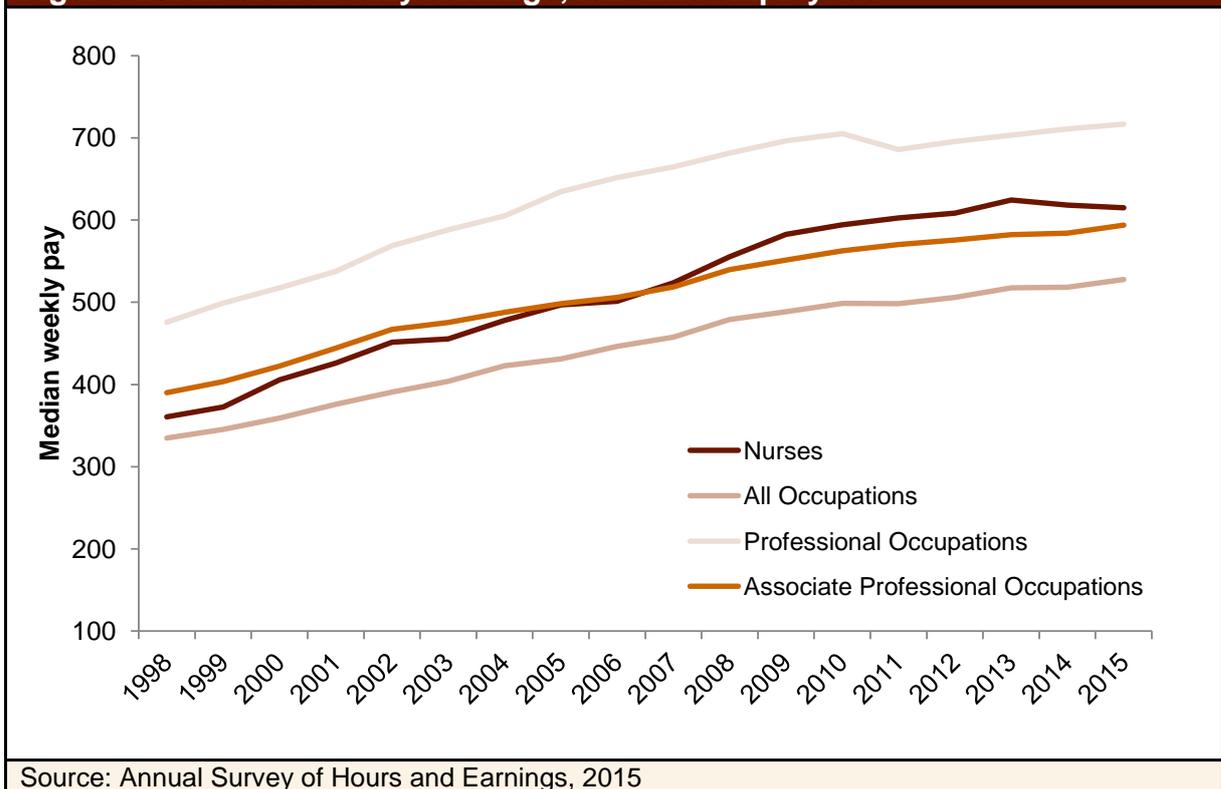
4.69 However, this assumes that an unconstrained (or a relatively unconstrained) market is operating. The majority of nurses in the UK are employed by the NHS, where wages are set by the Government, and based on the recommendations of the NHS Pay Review Body. The Government has set an aim of keeping annual public sector pay growth at 1 per cent until 2020. With this constraint, nurses' pay will not respond to shortage, as it would be expected to in a competitive labour market.

4.70 According to the Annual Survey of Hours and Earnings (ASHE), in 2015 the *median* pay for all full-time qualified nurses in the UK was £31,500, down by 0.3 per cent from the previous year but up by 1.5 per cent since 2012. Since 2010, nurses' pay has been falling in real terms, which means that, once inflation has been taken into account, the real nurses' pay has

been falling. The RCN estimate that, since 2008, there has been a cumulative real terms (Retail Price Index adjusted) fall of 9.6 per cent in the weekly earnings of full-time nurses. However, over the last five years or so wage growth generally in the UK has been subdued. Therefore, nurses' wages appear to have fared better relative to the average for all occupations, which suffered a 10.2 per cent fall in real terms, and particularly when compared to the average for professional occupations which fell by 15.1 per cent in real terms over the same period.

4.71 We explained in Chapter 1 that the skill level for nurses is National Qualifications Framework level 6 and above (NQF6+). Nurses are typically paid less than other occupations skilled to this same level. Using data from ASHE, we estimated that, in 2015, nurses were paid approximately £7,500 below the median pay for all occupations skilled to NQF6+. Figure 4.9 shows that the nominal wages for nurses have been consistently below the median pay for professional occupations. Nursing was categorised as an associate professional occupation until 2011, when it was reclassified as a professional occupation.

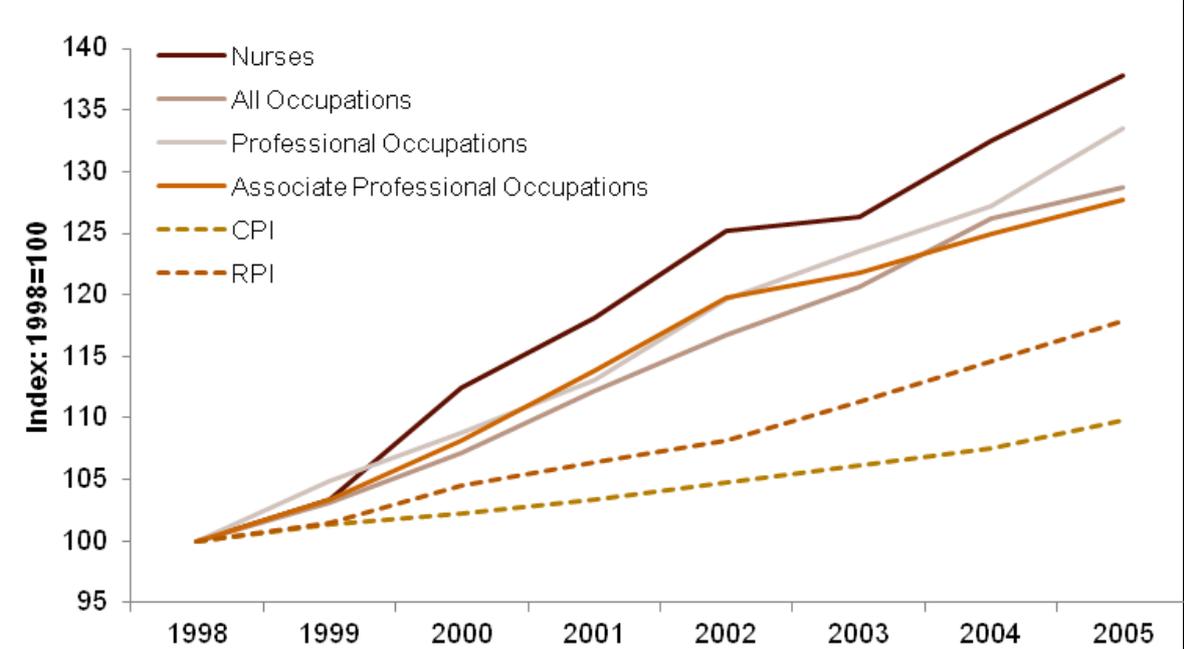
**Figure 4.9: Median weekly earnings, full-time employees**



4.72 Figures 4.10, 4.11, and 4.12 show the growth of nurses' pay relative to other occupations and to inflation. Apart from a brief slowdown in 2002, and again in 2005, nurses' pay grew strongly between 1998 and 2010. After 2010, pay for nurses began to level off and drop below inflation. Pay for nurses rose faster than other occupations for most of the period between 1998 and 2014, but, since then, has dropped below the median weekly pay across all occupations.

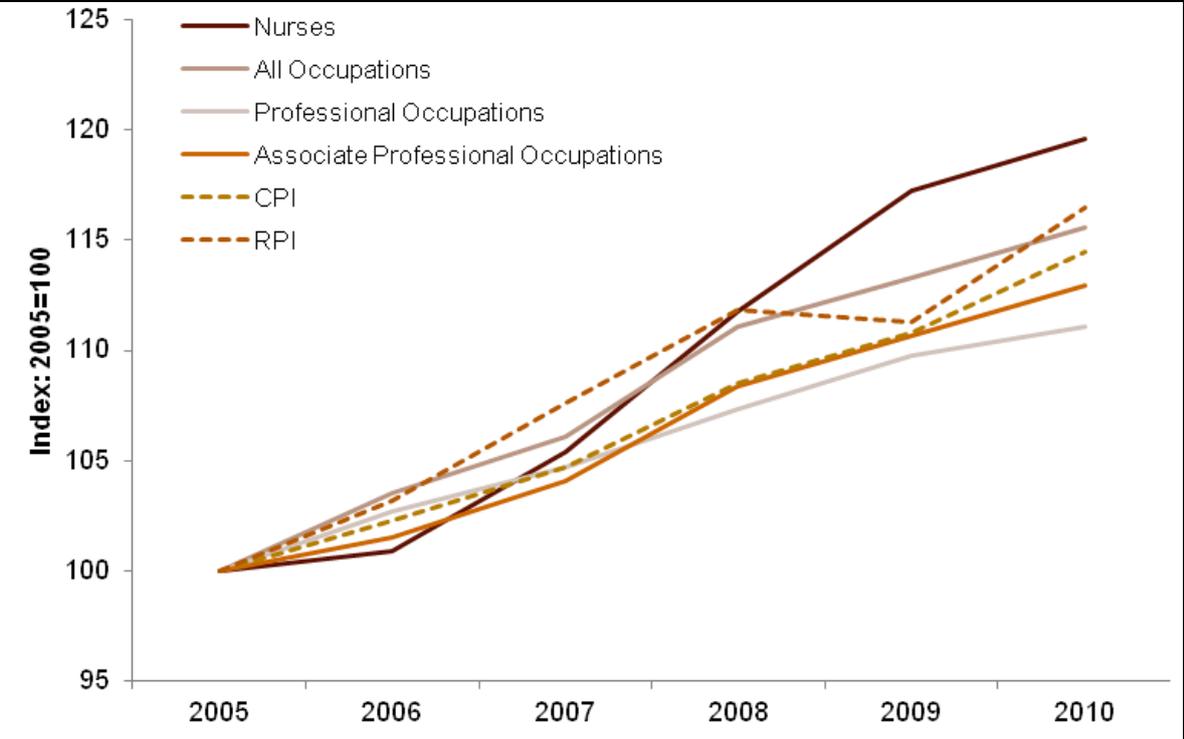
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**Figure 4.10: Median Weekly earnings, 1998-2005, full-time employees, 1998=100**



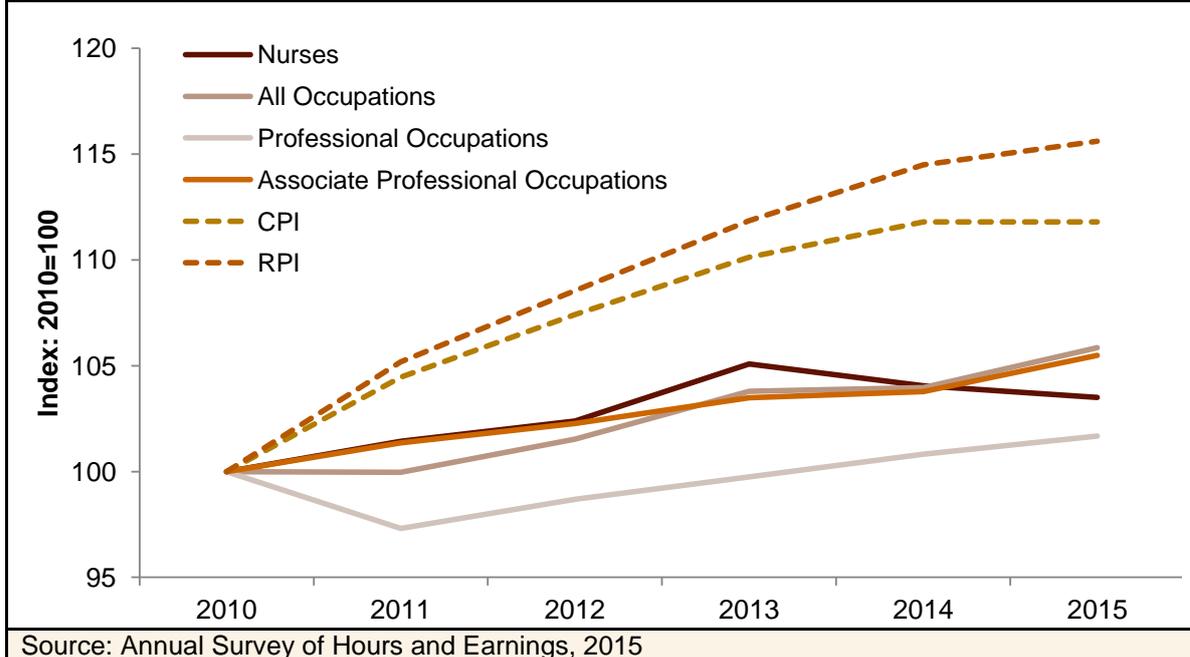
Annual Survey of Hours and Earnings, 2015

**Figure 4.11: Median Weekly earnings 2005-2010, full-time employees, 2005=100**



Source: Annual Survey of Hours and Earnings, 2015

**Figure 4.12: Median Weekly earnings 2010-2015, full-time employees, (2010=100)**



- 4.73 To maintain its value in real terms (RPI adjusted), the median wage for nurses would have had to increase by approximately 16 per cent between 2010 and 2015. The nominal median wage has increased in fact by only four per cent.
- 4.74 Whilst the figures above portray the overall trends in pay for nurses in the UK, the labour market for nurses can be split into several distinct components with different factors affecting pay and conditions. The majority of nurses in the UK are employed by the NHS, and are paid in accordance with national payscales. Outside the NHS, nurses' pay does not have to follow the same payscales. However, partners told us that the ability of care homes to increase pay is affected by the rates care homes can charge for the services they provide, a large proportion of which are purchased by the NHS and local authorities. Often, local authorities are able to use their buying power to dictate prices and secure lower rates (Independent Age, 2015). Finally, nurses in independent hospitals and agencies are also outside the NHS payscales and their pay is determined by what the market will bear. We consider each of these groups in turn below.

### Pay in the NHS

- 4.75 Partners from the NHS told us they have had great difficulty recruiting nurses to fill vacancies over the last year. This should manifest itself in higher pay, as individual employers compete for scarce nurses, with those employers offering the lowest wages losing out.
- 4.76 However, pay levels for NHS nurses are fixed by Agenda for Change. It allocates posts to set pay bands using a job evaluation scheme. Staff are placed in one of nine pay bands on the basis of the knowledge,

## Review of nursing

responsibility, skills and effort required for the job. Within each band, an employee can receive incremental pay above the minimum to reflect additional skills and experience. This set structure means that there is limited flexibility for NHS salaries to adjust rapidly to reflect changing labour market conditions.

- 4.77 The original Agenda for Change pay scales were introduced in 2004 and are reviewed annually by the NHS Pay Review Body. Table 4.2 sets out the Agenda for Change pay scales for nurses effective for the period 2015-16. There is some slight variation in these rates of pay across the devolved administrations: pay is marginally higher for nurses in Scotland and marginally lower in Northern Ireland in comparison to England and Wales.

**Table 4.2: Agenda for Change pay bands for nursing and midwifery (from 1 April 2015)**

	England	Wales	Scotland	Northern Ireland
Pre-registration candidate nurses (Band 3 and equivalent)	£16,633	£16,434	£16,960	£16,271
Band 4 and equivalent	£19,027	£19,027	£19,502	£18,838
Band 5 and equivalent	£21,692	£21,692	£21,818	£21,478
Band 6 and equivalent	£26,041	£26,041	£26,302	£25,783
Band 7 and equivalent	£31,072	£31,072	£31,383	£30,764
Band 8a and equivalent	£39,632	£39,632	£40,028	£39,239
Band 8b and equivalent	£46,164	£46,164	£46,625	£45,707
Band 8c and equivalent	£55,548	£55,548	£56,104	£54,998
Band 8d and equivalent	£65,922	£66,581	£67,247	£65,922
Band 9 and equivalent	£77,850	£78,629	£79,415	£77,850

Source: Agenda for Change (2015)

Notes: These are the minimum salary points within each band. Employees may receive increments above the band minimum to reflect skills and experience.

- 4.78 Salaries paid under each band can be varied slightly to take into consideration local living costs and recruitment and retention difficulties. This is discussed in more detail later in this section.
- 4.79 In 2010, there was a public sector pay freeze that lasted for two years. Since then, annual public sector pay rises have been capped at one per cent, and the Government has indicated they will continue with this approach until 2020. In 2014, the Department of Health declined to give those staff who were due to receive an annual progression pay increase the one per cent increase recommended by the NHS Pay Review Body. UNISON told us that by 2016, Agenda for Change salaries for NHS staff will have fallen by between 12 and 18 per cent in real terms compared with 2010.
- 4.80 In the late 1990s, the UK experienced a severe nursing shortage, with low pay and the increasing cost of living identified as causal factors (Finlayson et al. 2002). The NHS responded to the shortage by increasing wages, offering an overall increase of 4.7 per cent in 1999, accompanied by a 12

percent increase for newly qualified nurses. Between 1999 and 2001, the NHS Pay Review Body recommended additional pay increases above the annual increment offered to all nursing staff in order to increase recruitment and retention. Since 2006, the annual pay increments for nurses in the NHS have mostly been around 2.5 per cent or lower, with, as stated above, annual increases of one per cent less since 2011-12 (Table 4.3).

<b>Table 4.3 NHS Pay Review Body recommendations</b>			
<b>Financial Year</b>	<b>Percentage increase</b>	<b>Additional recommendations</b>	<b>Change in median hourly earnings for all full-time workers</b>
1996/97	2		-
1997/98	3.3		-
1998/99	3.8	To improve scope for career progression and provide increased flexibility in job design and appropriate reward, additional discretionary payments were recommended for certain grades.	4.3
1999/00	4.7	Recommended a 12 percent increase in the minimum starting salary for a qualified nurse (grade D).	4.1
2000/01	3.4	Recommended that grade C employees receive a pay increase of 7 per cent	3.6
2001/02	3.7	To encourage recruitment and retention psychiatric nursing should receive increases by 32 per cent, and on-call and standby payments should be increased by 50 per cent.	4.7
2002/03	3.6		4.5
2003/04	3.225	Recommended a three-year pay award of 10 per cent (3.225 per cent each year at April 2003, April 2004, and April 2005).	3.4
2004/05			4.9
2005/06			3.1
2006/07			3.3
2007/08	2.5		3.1
2008/09	2.75		4.4
2009/10	2.4		3.7
2010/11	2.25		1.2
2011/12	0		0.5
2012/13	0		1.5
2013/14	1		2.3
2014/15	1		0.2

Source: NHS Pay Review Body reports (1996-2014)

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4.81 It would appear that, during the previous nursing shortage, action was taken to raise the pay of nurses in order to encourage recruitment and retention in the profession. As we discussed in Chapter 2, the underlying circumstances at the time were somewhat different: the government was seeking a rapid expansion of health resourcing in the early 2000s. However, the overall effect was the same – an inability to source sufficient UK nurses. This time around, the NHS Pay Review Body have not recommended a pay increase over the 1 per cent laid out by the Government, nor offered any additional pay increases aimed at specific grades or specialities. In November 2015, the NHS Pay Review Body received an annual remit letter from the Department of Health commissioning the 2016-17 pay review with instructions to “*make recommendations within an average of 1 per cent for staff employed under the Agenda for Change*”.

### *Pay flexibility within Agenda for Change*

4.82 As described above, there is some flexibility to vary pay within Agenda for Change. The options available for the adjustment of NHS nurses’ pay in response to local recruitment conditions include:

- *High Cost Area Supplements (HCAS)* – where local living costs are high and this negatively impacts recruitment and retention, then the Agenda for Change pay structure allows for these locations to pay a nationally approved HCAS. In practice this allows for salary uplifts of 20, 15 and five per cent (up to an absolute ceiling) for those working in inner, outer and fringe areas of London respectively (IFS, 2015).
- *Recruitment and Retention Premia (RRP)* – NHS trusts are allowed to pay a premia to certain hard-to-fill occupations in order to boost recruitment. The RRP has to be applied to *all* employees working in this occupation, not just specific vacancies that are difficult to fill (IFS, 2015).

4.83 NHS Trusts that have achieved Foundation status, and therefore have greater local autonomy, also have the flexibility to vary pay scales from the Agenda for Change structure. Furthermore, each NHS organisation is given an individual Market Forces Factor (MFF) value to account for cost differences between health care providers, and this is independent of the HCAS. The MFF is not a direct mechanism to increase nurses pay, but it does affect the amount of money a trust has and therefore affects their ability to offer higher wages.

4.84 Though there is some flexibility under Agenda for Change, the Department of Health told us that these options are not widely used by trusts.

*“A second form of flexibility is that NHS Trusts are permitted to pay local Recruitment and Retention Premia (RRP) for hard-to-fill occupations, although this facility does not appear to be used a great deal given that such premia have to be paid to all employees in that occupation within the NHS Trust and not simply applied to specific hard-to-fill vacancies.”*

Department of Health response to MAC call for evidence

- 4.85 The IFS (2015) report discusses instances of grade drift and incremental drift where employees might be assigned to higher grades, or higher points of the grade scale, in order to relieve recruitment and retention pressures. One NHS Trust told us that they have used grade drift in order to attract and maintain permanent staff members. Upward grade drift is likely to be a problem when recruiting domestically but downward grade drift is more likely when recruiting non-EEA nurses as they are typically from countries where even the bottom of Band 5 offers a sizeable pay increase over what they could earn in their own countries.
- 4.86 The evidence we received was that trusts are not using the available options for flexibility within the Agenda for Change pay structure. It is not clear that these options are sufficient to address a widespread shortage given the financial pressures many trusts are under. The Department of Health told us that the RRP cannot be used to raise pay in isolated cases in order to attract extra nurses. Instead, the RRP requires that the wages of all nurses in the same post are also increased. However, this is a manifestation of the general increase in wages that we expect to see in response to a labour shortage in a well-functioning labour market. We find it difficult to imagine a private sector employer with a 30 per cent vacancy rate (as reported by some trusts) not concluding there is a serious problem with the attractiveness of their employment offer, and seeking to improve this through increased pay.
- 4.87 In an effort to improve recruitment whilst keeping costs down, the Oxleas NHS Trust in London has offered newly qualified nurses the option to opt out of their pension and receive employer contributions directly through their salary instead. This is an example of how trusts are developing alternative recruitment strategies, and are moving away from the traditional options available for increasing pay due to the restrictions in funding available.
- 4.88 The reluctance to use general levels of pay to resolve shortages has led to trusts using other methods such as grade drift, or employing agency nurses to get around the rigid pay structure. We will look in the next chapter at whether that also extends to employing non-EEA nurses.

### **Pay in the care sector**

- 4.89 There are no formal pay structures setting nurses' wages in the care sector. Skills for Care (2015) estimates that the mean wage for a

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registered nurse in the care sector is £24,300, which is in line with Agenda for Change Band 5 but is lower than the *mean* wage for nurses overall, which is £31,600 (ASHE, 2015). This may be due to compositional effects as it is likely that the NHS has a higher proportion of senior and specialist nurses compared to the care sector.

- 4.90 Partners from the care sector told us that the majority of their services are purchased by local authorities or the NHS at set rates. Local authority budgets have experienced even greater financial pressures than the NHS budget since 2010 and this inevitably translates into less funding for social care. Therefore, they have only limited flexibility to raise prices in order to pay higher wages. Some care providers said that there is a gap between the public funding they receive and the true cost of care, which is currently subsidised by charging higher fees to their paying residents.

*“It is very difficult for adult social care providers to raise pay because of the inadequate funding received from local authority and NHS fees for the residents that they care for.”*

Bupa UK response to MAC call for evidence

- 4.91 However, despite this constraint, the Care Associate Alliance assert that in 2014, nurse pay rates in the care sector went up by three per cent nationally in response to shortages, significantly above the one per cent within Agenda for Change.

*“Nurse pay rates went up by 3% in 2014 in social care establishments, significantly above the 1% within Agenda for Change. This increase would have come straight out of profit margins for many of these employers as there were real term decreases in the income from local authorities.”*

Care Association Alliance response to MAC call for evidence

- 4.92 One UK care provider presented evidence on their average pay in recent years and this is set out in Table 4.4. Between 2012 and 2015, their hourly pay for nurses increased by 10 per cent.

**Table 4.4: Increases in nurses pay for one care provider in the UK**

	2012	2013	2014	2015 (to November)
Average hourly rate (£)	11.87	12.02	12.51	13.03
Annual growth	-	1.24%	4.07%	4.17%

Source: One care provider's response to MAC call for evidence (2015)

- 4.93 Many partners from the care sector said that they found it difficult to compete with the NHS for nurses because the NHS is able to offer higher pay, better terms and conditions, and better career development opportunities. The Department of Health also acknowledged this issue,

pointing to a hierarchy with agencies at the top, followed by NHS employment, followed by social care.

*“Agencies offer higher pay rates, better flexibility and reduced administrative responsibilities compared to the NHS; and the NHS offers better skills training and benefits compared to the social care sector.”*

Department of Health response to MAC call for evidence

4.94 Following a similar pattern to the NHS, care service providers who are unable to fund an increase in nurse pay told us that they were turning to agency nurses and foreign labour markets to bridge the gap between supply and demand.

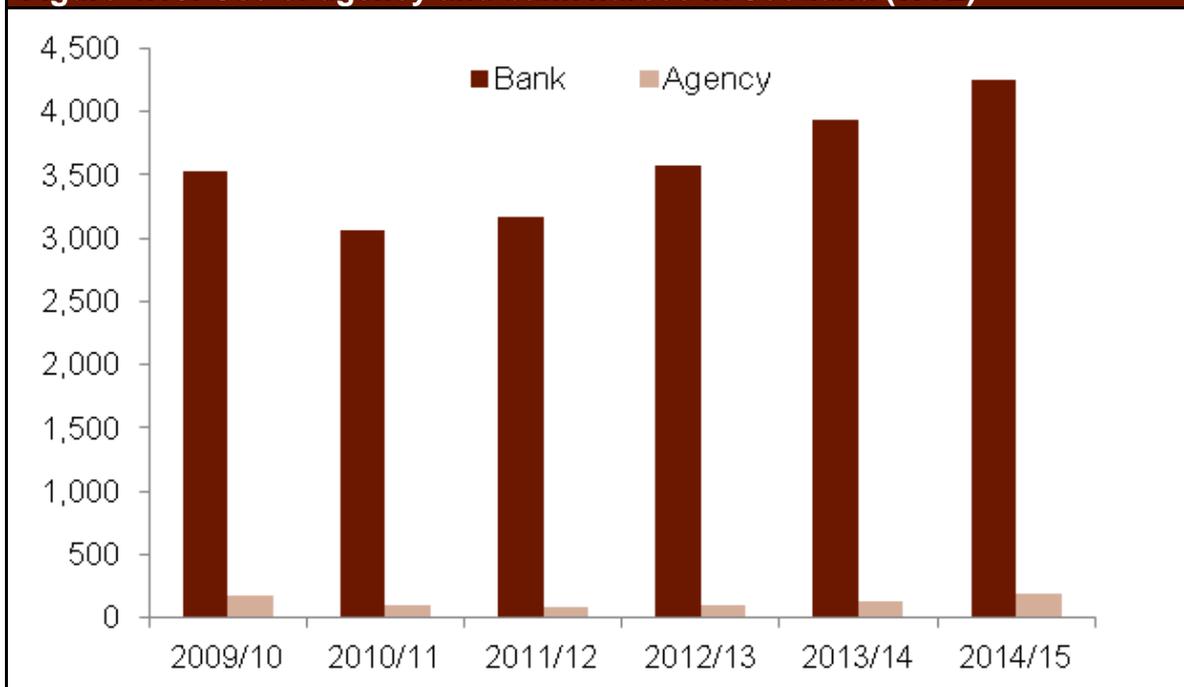
### **Pay for agency nurses**

4.95 We would expect pay rates for agency nurses to be more responsive to supply and demand because they operate under more flexible market conditions. Unfortunately the lack of robust data in this area inhibits a proper assessment of this. In the absence of comprehensive data on agency pay rates for nurses, partners told us that these have increased in recent years to reflect the shortage of nurses in the UK.

4.96 NHS Improvement recently released a clinical workforce report (NHS Improvement, 2016), which found that the limited supply of nurses had resulted in a 30 per cent increase in unit agency costs between 2012 and 2015. The NAO reported (NAO, 2016) that in the two years to 2014-15 hourly agency rates for nurses increased by nine per cent.

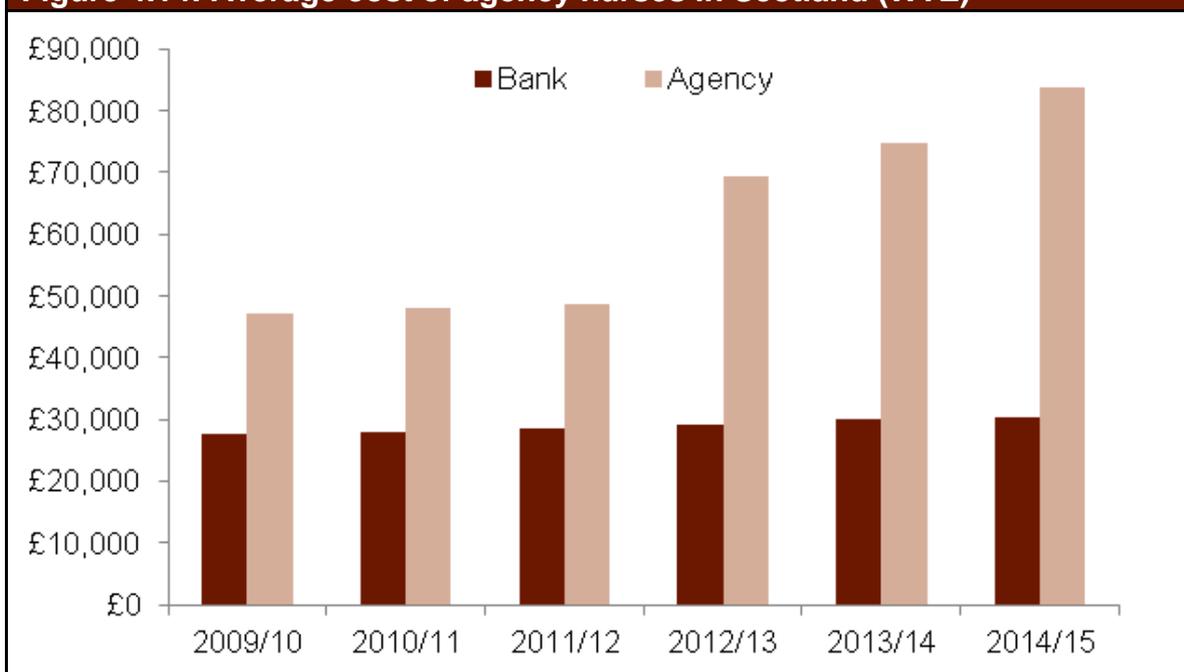
4.97 Scotland has better, official data on the usage and cost of both agency and bank nursing. These show a simultaneous increase in the use of agency nurses, and a substantial rise in the price of agency nurses, as shown in Figures 4.13 and 4.14. Relative to bank working, agency usage is relatively small, but has been increasing since 2011-12. The average cost for agency nurses has risen dramatically over this period to the equivalent of £80,000 a year for a nurse (on an FTE basis) from less than £50,000 in 2011-12 (Box 2.1 in Chapter 2 explains the difference between bank and agency nurses).

**Figure 4.13: Use of agency and bank nurses in Scotland (WTE)**



Source: MAC analysis of Information Services Division Scotland NHS workforce statistics (2015)

**Figure 4.14: Average cost of agency nurses in Scotland (WTE)**



Source: MAC analysis of Information Services Division Scotland NHS workforce statistics (2015)

*Use of agency nurses in the NHS*

4.98 The NHS is a large user of nursing agencies. The RCN produced a report (Royal College of Nursing, 2015b), which estimated that the NHS in England was on track to spend at least £980 million on agency nursing staff by the end of the 2014-15 financial year. This is equivalent to 9 per cent of total NHS expenditure on nursing and midwifery staff.

- 4.99 The RCN report obtained information from 168 acute, community and mental health and specialist acute provider NHS trusts in England. Collectively, these trusts spent £327 million on agency nurses in 2012-13. In 2013-14, this figure rose to £485 million. In the three-month period July-September 2014, on average, trusts were spending in excess of £1million each on agency staff. For the period July to September 2014, half of trusts doubled their spending on agency nurses compared to the same period in 2012.
- 4.100 In 1999-00, at the time of the previous nursing shortage, expenditure on temporary nurses accounted for 10 per cent of total expenditure on the overall nursing workforce (both the NHS and care sector). Agency spending in the NHS alone peaked at 7 per cent in 2001-02, and then fell to three percent by 2004-05. In nominal terms, current agency spending in the NHS has surpassed the highest rate it reached in the previous nursing shortage (House of Commons, 2007).
- 4.101 Monitor, the sector regulator for health services in England, recently introduced caps to limit the rates NHS trusts can pay to agency workers as a proportion of Agenda for Change paycales. From April 2016, the maximum charge for agency staff will be 55 per cent above the basic substantive hourly rates. Monitor said that the price caps are intended to encourage staff to return to permanent and bank working, and enable trusts to manage their workforce in a more sustainable way.
- 4.102 Although the limits on NHS spend may serve to reduce pay to agency nurses, partners told us that many nurses still prefer agency work because of the greater flexibility it offers. However, it is possible that future behavioural effects will be greater as the impacts of the cap are felt by agency nurses.

### *Use of agency nurses in the care sector*

- 4.103 Care England expressed concern that care providers presently had no choice but to rely on nursing agencies that charged up to £50 per hour, and did not deliver the quality of care that permanently employed nurses due to a lack of familiarity with patients and a lack of accountability given the temporary nature of their employment. The Macklin Group, who run several care homes in Northern Ireland, emphasised that agency rates have increased at regular intervals as the shortage of nurses has become more acute.

*“The challenges are...extortionate agency costs with hourly charges being increased by some 6 monthly as they are aware of the staff shortage and supply and demand issue”*

The Macklin Group response to MAC call for evidence

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- 4.104 Although steps are being taken to reduce the financial burden of agency staff on the NHS, there is no cap on agency spending in the care sector other than the financial limits of the care providers.

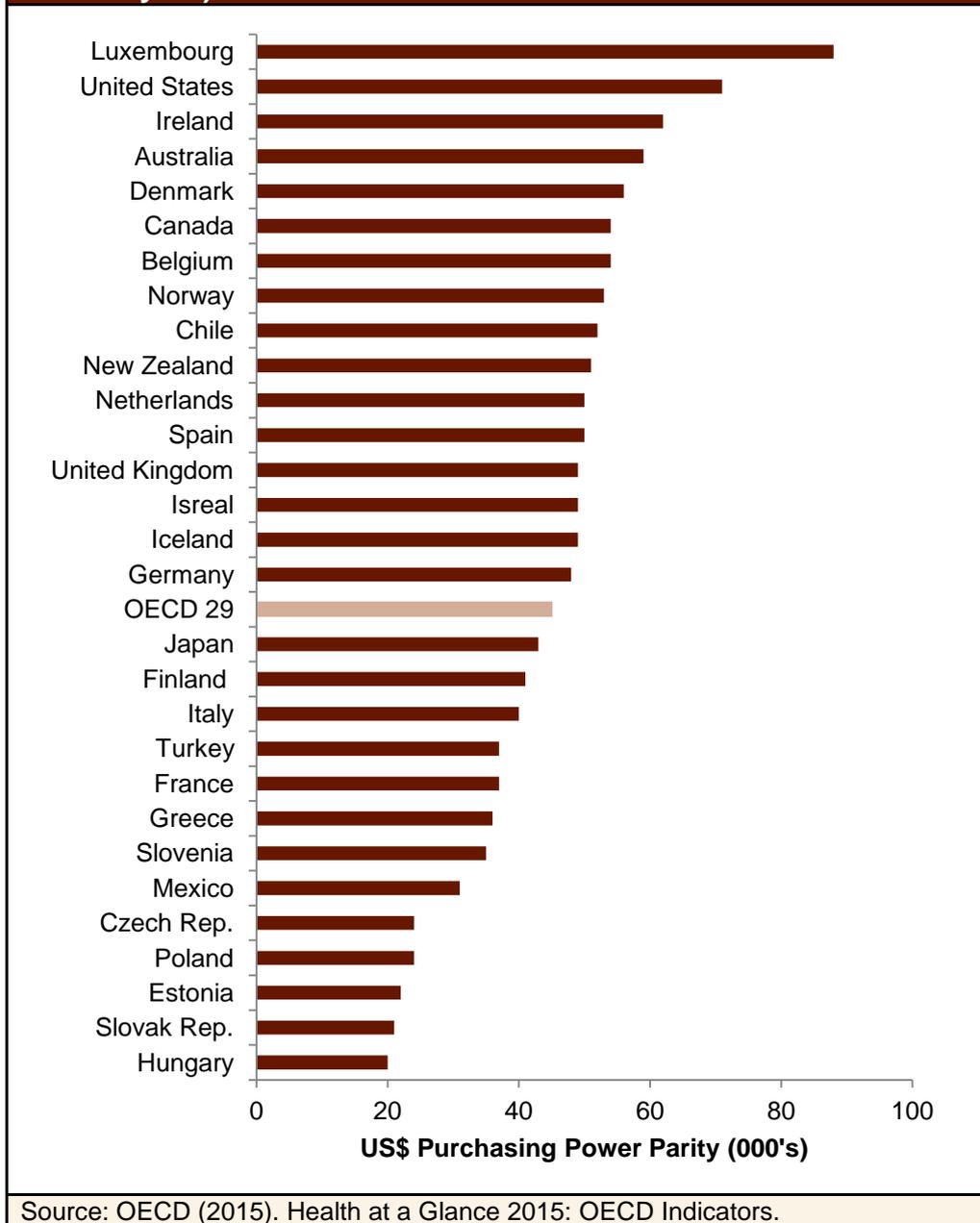
*“For social care providers...there is no nationally recognised cap and this, coupled with ever increasing competition for agency staff from the NHS, acts to increase costs even further for social care employers that are short of nurses. Such reliance on temporary staff to fill rostered hours has led to an increase in spend on agency staff in the largest care home groups of almost 55% over the past two years.*

Care Association Alliance response to MAC call for evidence

### 4.5 International comparison of nurses' pay

- 4.105 A recent study by the OECD analysed hospital nurses' pay across OECD countries. In 2013, in most OECD countries the remuneration of hospital nurses was at least slightly above the average wage of all workers in that country. In the UK, remuneration for hospital nurses was 10 per cent above the average wage for all full time workers in the UK (OECD, 2015a).
- 4.106 Figure 4.15 compares the pay of hospital nurses in OECD countries. Although the UK is slightly above the OECD average, hospital nurses in the UK are, on average, paid significantly less than hospital nurses in Australia, the USA and Ireland; these are the most popular destination countries for UK registered nurses who choose to work abroad.

**Figure 4.15. Remuneration of hospital nurses, USD PPP, 2013 (or nearest year)**



## 4.6 Summary

4.107 There was widespread agreement amongst partners as to the factors contributing to increased demand for nurses in the UK. Long-term demographic trends together with health care reforms and in nurses' jobs had increased demand for nurses across the NHS Trusts, social care and private health care providers, who were competing for fewer nurses from the same pool.

4.108 On the supply side, there were a number of explanations offered as to why supply was not sufficient to meet current demand. On recruitment, partners highlighted the decision to cut training places, partly driven by financial concerns. But partners also highlighted more general failures in

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workplace planning, with insufficient attention paid to demand in the care and independent sectors. This had built in a structural undersupply, the impact of which had been exacerbated when better integration of health and social care became a key policy aim. Equally, there are a number of issues linked to retention that contributed to supply issues. Nurses are choosing to leave employment as a nurse in the UK, whether to retire early, to follow an alternative profession, or to work as a nurse overseas. High exit rates from nursing can be just as important a contributor to shortage as insufficient training places.

- 4.109 Finally, we consider pay growth to be an important indicator of shortage, but pay for NHS nurses is presently restrained. There is clear evidence of substantial increases in agency pay rates, and more modest but still significant increases in pay in the care sector. There is also evidence to suggest that pay could be a key driver of poor retention of nurses in permanent roles in the NHS and care sectors, with many nurses moving to agency work or leaving the profession altogether. In Chapter 5, we will further consider whether wage increases could be more fully explored as a tool to help alleviate the nursing shortage, either in the short or the long term.

## Chapter 5: **Sensible**

### **5.1 Introduction**

5.1 This chapter considers the sensible part of the MAC methodology. The MAC considers four indicators of whether it is sensible to employ migrants from outside the European Economic Area (EEA) and these are set out in our previous reports on shortage and in our call for evidence. In relation to this review of nurses, we have looked specifically at four questions that we think involve the key issues to determine whether it is sensible to recommend retaining nurses or nursing specialties on the shortage occupation list (SOL). We look below at the evidence we received in relation to each question in turn. The questions are:

- Is there an underused UK supply of nurses, which could help to address the shortage?
- Would training more nurses have an impact on the numbers of non-EEA nurses coming to the UK?
- What is the role of improvements in pay and conditions?
- What other sources of nurses are there?

5.2 Following on from these questions, we consider whether the employment of non-EEA nurses is being used to mask longstanding deficiencies in workforce planning or to keep pay down, and whether the measures put in place to close the supply gap are convincing. Last, we consider whether there are any conditions that should be attached to nurses if they are retained on the SOL.

### **5.2 Is there an underused UK supply of nurses, which could help to address shortage?**

5.3 Employers are running schemes to encourage nurses who have left the profession to return to practice. We looked at the extent of the reservoir of trained nurses not currently practising the profession and whether this could serve to make up any shortfall in the supply of nurses.

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- 5.4 There is no reliable data source to identify the number of nurses who have left the profession. Using the Annual Survey for Hours and Earnings (ASHE) from 1997-2012, the Institute for Fiscal Studies (IFS) sought to identify the number of individuals aged 20-59 working as nurses within the NHS and outside the NHS as well as individuals who have worked as nurses in the past but now work in an alternative occupation (Crawford *et al.* 2015)). At any one time, on average just under 70 per cent of potential NHS nurses work as NHS nurses, with just over 10 per cent working as nurses outside the NHS. The remainder are found working in other occupations. The IFS study also found that the proportion of potential NHS nurses actually working as NHS nurses at a given point in time is significantly higher the further the region is from London, which they attribute to the greater availability of alternative jobs in London.
- 5.5 Using the Labour Force Survey, we have carried out our own analysis of the potential supply of nurses, based on individuals who have a nursing degree or who are currently or have previously worked as a nurse. Table 5.1 shows that there are approximately 698,000 individuals currently employed within the UK that have the potential to work as qualified nurses. Of this potential supply, approximately 630,000 individuals (90 per cent) are currently working as nurses; 502,000 (72 per cent) as nurses within the NHS. In addition, there are approximately 78,300 potential nurses aged 65 and under who are inactive, and fewer than 10,000 who are currently unemployed.

**Table 5.1: Potential supply of nurses with a nursing degree, Labour Force Survey, year ending September 2015.**

	England	Wales	Scotland	Northern Ireland	Total
<i>In employment</i>	559,000	41,900	71,700	25,800	698,000
As nurses	503,000	38,600	64,400	24,600	630,000
- Within the NHS	400,000	33,600	49,200	18,900	502,000
Other	56,200	-	-	-	68,100
<i>Inactive</i>	99,200	10,700	11,800	-	124,000
Aged 65 and under	60,600	-	-	-	78,300
<i>Unemployed</i>	-	-	-	-	-

Source: MAC analysis of Labour Force Survey, Office for National Statistics, Q4 2014-Q3 2015.  
 Notes: Nurses are defined by SOC10M=2231. Potential supply includes individuals whose last job was as a nurse (SOC10L/SOC10R) and those who have a 'nursing' degree (fdsndgdeg=2.7). Region defined by region of residence (uresmc). (-) indicates an estimate lower than 10,000 which is not published due to small sample sizes. The analysis is illustrative only and should not be interpreted as an accurate estimate of the number of individuals qualified as nurses. Figures rounded to 3 significant figures.

- 5.6 Included within those in employment with a nursing degree, there are over 48,000 individuals working in medical or health related occupations, such as midwives and paramedics.

- 5.7 Table 5.2 shows the main reasons for inactivity for those with a nursing degree. The majority (39,900) are retired and would not like work. However, over 13,000 individuals are inactive who would like work, including those that are looking after the family/home or who are temporarily sick.

**Table 5.2: Main reasons for inactivity of individuals with nursing qualifications, Labour Force Survey, year ending September 2015.**

Retired (would not like work)	39,900
Looking after family/home (would not like work)	10,100
Other (would not like work/unavailable), incl. long term sick/disabled, does not need/want employment, other	14,400
Other (not seeking, would like work), incl. looking after family/home, long term sick/disabled, temporarily sick/injured, retired, other	13,900
Total	78,300

Source: MAC analysis of Labour Force Survey, Office for National Statistics, Q4 2014-Q3 2015.

Notes: Inactive nurses include individuals whose last job was as a nurse (SOC10L/SOC10R) and those who have a 'nursing' qualification (fdsndgdeg=2.7). Figures rounded to the nearest 3.s.f.

- 5.8 These are likely to be underestimates as not all nurses have a degree. The data does not allow us to easily identify how many individuals have a nursing qualification. An overestimate, which, due to the format of the survey, may include individuals with other (non-nursing) medical qualifications, would be that there are approximately 1,009,000 individuals with a nursing qualification in employment, of which 630,000 are registered nurses and 379,000 are employed in other occupations. The overestimate also includes 174,000 individuals aged 65 and under who are inactive, and just over 10,000 who are unemployed. In reality, the exact figures are likely to be between our under- and over-estimates. However, we do not have the necessary data to provide a more accurate estimate.
- 5.9 As stated previously, these estimates are illustrative only. We are concerned that neither the Department of Health nor any of the other bodies with responsibilities for the supply of nurses seem to be carrying out this type of analysis to the extent of having a better picture of the size of the potential nursing supply.

### Return to practice

- 5.10 The Department of Health told us that there are four main categories of nurse who are on the Nursing and Midwifery Council (NMC) register but who are not currently employed as a nurse. But the Department did not supply us with an indication of how many persons fall into each category. The categories are:
- Those who remain in the UK but are on a career break (e.g. family or study).

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- Those who remain in the UK but have gained employment in another role or sector.
  - Those who have moved abroad but who have either sought to maintain their registration, or it has not yet lapsed.
  - Those who have retired but whose registration has not yet lapsed.
- 5.11 Health Education England (HEE) have a Return to Practice initiative aimed at the first category, those who remain in the UK but are on a career break. They initiated a Come Back to Nursing campaign and associated return to practice education and support. HEE said that in the academic year 2014-15, 1,504 nurses commenced return to practice programmes and 160 of the September 2014 starters have gone on to full time employment. HEE aim to deliver similar volumes in 2015-16.
- 5.12 Some of those who have left the profession but have gained employment in another role or sector might also be attracted back to nursing. However, such persons presumably sought other employment because it was more attractive, so would be unlikely to return unless the pay and conditions of a nursing career were improved. The third category, nurses working abroad but still NMC registered, may also see some return to the UK but again the numbers are likely to be small. The Organisation for Economic Co-Operation and Development (OECD) estimated that in 2010-11 there were almost 52,000 nurses from the UK working in other OECD countries, with the UK being ranked third in terms of numbers of the most common nationalities of foreign born nurses, behind the Philippines and India (Organisation for Economic Co-Operation and Development (2015)). With the right incentives, some of these nurses could move back to the UK.
- 5.13 The Department of Health said that there is also a fifth category, which unlike the four above, requires re-registration – namely, those qualified nurses below retirement age who have let their NMC registration lapse and are working in another role or sector. To re-register, nurses must complete paperwork and pay a fee of £120.
- 5.14 NHS Education for Scotland are running a return to practice initiative for nurses in Scotland whereby returnees are able to apply to have their university programme fees (£1500) fully paid and can also claim assistance with their learning expenses. NHS Wales offer a return to practice scheme for nurses including payment of course fees, £1,000 bursary, and payment of childcare costs.
- 5.15 The numbers taking up the return to practice scheme in England are relatively small. We do not have figures for the numbers participating in such schemes in the devolved administrations. In order for such schemes to succeed in the long-term, the pay and conditions on offer have to be tempting enough to make people come back and to make them stay. Without this, it may be more cost effective to seek to retain nurses and reduce workforce attrition than to lure them back once they have left the profession.

- 5.16 Partners told us that the retention of nurses is also compromised by competition from other employers. Healthcare providers in other countries offer nurses permanent positions after one year of NHS experience. Agencies offer higher pay rates, better flexibility and reduced administrative responsibilities (although they also do not offer holiday or sick pay or pension). The NHS offers better skills training and benefits compared to the social care sector. Partners expressed concern at the ability of staff to leave for better offers elsewhere. But a flexible labour market may not always function to the advantage of employers. Competition amongst employers for staff can be a good thing and those employers that are losing employees should, under normal circumstances, act to improve their offer to staff in order to make leaving a less attractive proposition.

### **5.3 Would training more nurses have an impact on the number of non-EEA nurses coming to the UK?**

#### **Recruitment of UK nurses**

- 5.17 Health Education England (HEE) is the body responsible for ensuring sufficient future supply of nurses in England for both the health and the care sectors. Each year, HEE provides local and national forecasts of the supply that will arise over the next five years and uses these forecasts to discuss with stakeholders whether this supply will match the future demand, including the extent to which any current shortages will be addressed.
- 5.18 HEE has published a commissioning and investment plan for 2016-17 (Health Education England, 2015), which sets out HEE's planned training commissions. This document points out that HEE's commissioning proposals have historically been constrained by the total amount of resource available to HEE. It goes on to highlight the recent government proposal that current bursary and fee arrangements for undergraduate nurses be replaced by student loans for new students from 2017. HEE say that while this change creates the opportunity for the future training volumes of nurses not to be constrained by the overall amount of funding available, they have not, in establishing their proposals for 2016-17, made any assumptions about the impact of this policy on future supply.
- 5.19 Chapter 4 set out figures pertaining to the numbers of nursing commissions in recent years. The HEE plan for 2016–17 forecasts a 5.5 per cent increase in demand for adult nurses in England in 2020 over demand in 2015, an additional 13,057 nurses. The plan forecasts that the supply of adult nurses in England in 2020 will fall between 237,416 and 213,428. This is a range that will deliver between 21,133 more nurses than presently in post and 2,854 fewer. The HEE plan makes the point that there are real risks that the forecast supply will not be fully achieved if employers are not able to improve the rate at which the workforce, other than retirees, is leaving the nursing profession.

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- 5.20 We were told that some NHS trusts had sought to put in place alternative training arrangements, outside the courses centrally funded by HEE. Box 5.1 describes one example.

### **Box 5.1: Alternative nurse training model**

To overcome problems associated with centrally determined nurse commissions, Lancashire Teaching Hospitals NHS Foundation Trust began working with the University of Bolton to develop a fee paying pre-registration nursing degree programme. The first intake was in February 2015.

Lancashire Trust was experiencing a shortfall of 200 nurses out of a total of 1,800 nursing posts. The Trust partnered with a local university (Bolton) that was not already a commissioned nurse training provider. The Lancashire Trust had previous experience of relatively high course attrition rates (up to 40 per cent in some cohorts) in addition to attrition from nurses in the first years working as a nurse after university and so were seeking a different model of nursing training.

One of the aims for the course developed with the University of Bolton was to foster more compassionate care skills. To achieve this, it focused on smaller cohorts and gave students and patient representatives more input into the curriculum as well as recruiting course tutors with more recent practice experience. Half of the practice-based learning was spent on a placement in a hospital and some of the academic tuition also delivered on the Trust's premises.

Students fund their own way through the course and the first intake in February 2015 accepted 15 students from 60 applications. For September 2015, there were 634 applications and 28 students were accepted. The February 2016 intake generated 192 applications.

Upon graduation, newly qualified nurses are guaranteed a Band 5 job with the trust, which also pays off the costs of the first year of training after each graduate, completes 2 years employment with the trust.

Other trusts in the North West region have now signed up to the model and there has been interest from other UK trusts seeking to establish similar models.

- 5.21 We assess HEE plans later in this chapter but we note here the caveats that HEE flag up and also the previous performance of the health sector in predicting demand for and supply of nurses. Chapter 2 highlights some historical peaks and troughs in nurse recruitment.

## **5.4 What is the role of improvements in pay and conditions?**

### **(i) Can pay be used as a tool to address shortage?**

- 5.22 We looked, in Chapter 4, at pay rates for nurses and whether there was flexibility to increase these. We look, in this section, at whether increases in pay would help to alleviate difficulties in recruiting and retaining nurses.
- 5.23 Employers, particularly within the NHS, said to us that pay was not a readily available tool that could be used to affect the supply of nurses. NHS employers told us that the pay of nurses was determined centrally and they did not have enough funding to afford a substantial increase in pay. The Department of Health maintained that organisation commitment and dissatisfaction with promotion and training opportunities had been

shown to have a stronger impact on nurse turnover than workload or pay. However, Eberth *et al.* (2015) found that where pay structures are relatively inflexible, as they are within the NHS Agenda for Change, the conditions under which nurses work and the timing and convenience of the hours they work become increasingly important determinants of the labour supply. The research indicates that it is the inflexibility of the pay structure that creates a heightened focus on other issues that impact on nurse turnover rather than these issues being more important, per se. Additionally, partners highlighted their view that even if pay was increased, there were genuine shortfalls in nursing numbers available that would take several years to fill domestically as new nurses are trained.

*“Nor would a pay rise alleviate the current nursing shortage, as there is no large untapped pool of qualified nurses available domestically who might be enticed back to nursing through better terms and conditions. Around nine in 10 registered nurses in England already work as nurses...Higher pay would make little contribution to expanding the existing nursing pool over the 3-4 year period we expect this occupation to be in shortage.”*

Department of Health response to MAC call for evidence

- 5.24 Partners told us that people chose to enter the nursing profession for reasons other than pay and that currently, at present pay rates, training places are oversubscribed. Partners said that it was therefore unclear that an increase in pay would increase the supply of nurses.

*“Pay is an important factor when looking at recruiting and retaining staff, although the evidence shows it is not the sole factor in determining whether an individual chooses to stay or leave a post.”*

NHS Employers response to MAC call for evidence

- 5.25 We accept that the decision to become a nurse may not be entirely driven by pay for most people. But that is not the same as saying that pay is not a factor in the decisions nurses and potential nurses make. For some, the relatively low pay may put them off nursing as a career. Others may choose to train as a nurse but leave the profession later in their career when pay becomes a more important factor in their decision-making. Alternatively, a nurse may choose to retire early because the pay is not sufficient for them to remain working.
- 5.26 A survey in Nursing Times (Nursing Times, 2015) reported that pay was the second highest factor in nurses seriously considering leaving the profession. Overwork and pressure was the largest factor by some margin.
- 5.27 HCL Workforce Solutions collected 85 survey responses from their locum staff. When asked the question “what originally attracted you to nursing?” 74 per cent of respondents cited care-related reasons, whereas only 12

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per cent did so because of financial reasons. Although pay did not appear to be a key driver of recruitment, it played a large part in the retention of nurses. Listed below in Box 5.2 are some of the responses given when asked why they thought there was a nursing shortage. Just over half of respondents listed pay related reasons. Other key causes included stress, poor work life balance and poor management.

### Box 5.2: Reasons for leaving nursing from HCL Survey

*“Terrible working conditions, long hours, no benefits, hours owing when you could probably do with the money. Unable to financially afford to undertake training. No work/life balance.”*

*“Nurses are poorly paid and aren’t valued as a profession.”*

*“Low morale, lack of appreciation, lack of respect, poor pay.”*

*“Working over time unpaid.”*

*“Lack of incentive to work in often such a difficult and undervalued environment where nursing and other health care professionals are given little consideration for the work that they do and a lack of respect from their employers. Very poor recruitment drives... Poor pay and working conditions are little incentive to encourage new recruits.”*

Source: Responses to HCL survey of nurses in response to MAC call for evidence

- 5.28 Furthermore, 45 per cent of respondents said that better financial incentives could encourage staff out of agency work and back into a substantive nursing role. The rules governing the price caps for agency staff recently published by Monitor and the Trust Development Authority (Monitor and Trust Development Authority, 2015) stated that part of the reason why price caps are being introduced is to encourage staff to return to permanent and bank working. So it would appear that the health sector does recognise that pay has an impact on people’s decisions about where to work.
- 5.29 Additionally, in their evidence to us, the Department of Health suggested that whilst some former nurses who have taken career breaks may be persuaded back, those who have left in pursuit of another profession presumably did so because alternative employment had a more attractive offer. It seems to us, therefore, that there is recognition that pay does affect employment choices.

*“...presumably they sought other employment because it was more attractive, so would be unlikely to return unless the pay and conditions of a nursing career improved”*

Department of Health response to MAC call for evidence

- 5.30 In 2015, the IFS published a paper (Crawford *et al.*, 2015) investigating the short run responsiveness of NHS nurses' labour supply to changes in the wages of NHS nurses, relative to wages of alternative outside options. The findings suggested that in areas where there are attractive outside options (such as in London), a higher proportion of potential NHS nurses work outside the NHS. Thus, the more competitive market for nurses meant that the elasticity of supply of nurses to the NHS is greater. The IFS said that, in London, a 10 per cent increase in pay might be expected to achieve a 7 per cent increase in nurse numbers. However, across most of the UK this same increase in pay might only translate into an increase in supply of less than 1 per cent. The report concluded that it would seem sensible to target pay increases solely towards those working in London, which could be done through enhancing high cost area allowances or recruitment and retention premia. Table 2.2 in Chapter 2 highlights that NHS trusts in London and the South East made a disproportionate use of CoS compared to trusts in other UK regions, indicating particular recruitment difficulties in London and the South East, consistent with the IFS findings about the importance of pay in these regions.
- 5.31 In Scotland, the Care Inspectorate told us that a similar situation was faced by care providers in areas that offered alternative employment, chiefly in the NHS.

*"We have been advised by some providers of care services that it is more difficult to recruit nurses in those areas where there are more opportunities in the NHS, because this may be preferred by some people to working in the care sector."*

Care Inspectorate response to MAC call for evidence

- 5.32 We set out in Chapter 4 how nurses' pay is determined. Ultimately, the government has set the parameters within which the pay review system currently operates. However, the government could choose to change these parameters if it wished.

*"Salaries of nurses in the NHS are ultimately controlled by government rather than market forces or the outcomes of free collective bargaining between unions and employers. Workers in the public sector have had their pay subjected to a public sector pay policy based on a two year pay freeze from 2010, followed by a 1% pay cap. This has meant that, despite the national shortage of nurses, pay has decreased by 9.5% in real terms over the past four years. In the Summer Budget 2015, the government stated that public sector salary increases would be held at 1% up to 2020 meaning real wages will fall further even as nursing shortages rise."*

TUC response to MAC call for evidence

## Review of nursing

*“By 2016, Agenda for Change salaries for NHS staff will have lost between 12% and 18% of their value since 2010.”*

UNISON response to MAC call for evidence

- 5.33 NHS Providers’ most recent evidence to the pay review bodies (NHS Providers, 2015) cited a survey of members asking whether there were any Agenda for Change staff groups that members thought should receive more than a 1 per cent pay rise in order to support service delivery or address recruitment and retention pressures. 36 per cent said yes, and adult general nurses were most commonly suggested for a higher pay award. NHS Providers said that in contrast, there were few suggestions as to which staff should receive less than 1 per cent as a result.
- 5.34 In its 2016 evidence to the pay review bodies, the Department of Health said that it did not believe there were significant recruitment and retention challenges across NHS staff (not just nurses) that would be resolved by awarding more than 1 per cent (Department of Health, 2016). The Department recognised workforce supply issues, in particular the supply of nursing staff, but did *“not believe the complete answer to workforce supply issues can be effectively resolved by targeting within a pay envelope of 1 per cent”* (sic) (Department of Health, 2016).
- 5.35 The Department told the review bodies that NHS employers locally had the flexibility to pay recruitment and retention premia to help resolve any local recruitment or retention problems, and that the latest figures showed a continuation of the downward trend in the proportion of staff receiving such a payment. NHS Employers, in their 2016 evidence to the Pay Review Bodies (NHS Employers, 2015), said that there were emerging workforce supply challenges for some key health professional groups across England, particularly in relation to qualified nursing staff and that this had led to a growth in spending on agency staff. From the evidence, it would appear that employers are preferring to pay agency rates rather than the recruitment and retention premia. This premia has to be paid to all employees, not just specific vacancies that are difficult to fill, and so, presumably, employees are choosing agencies as the cheaper option.
- 5.36 The structure of healthcare in the UK gives the NHS effective monopsony power: the NHS employs the large majority of nurses in the UK. Its monopsony power means the NHS does not have to relate shortage issues to pay. The NHS Employers’ evidence to the Pay Review Bodies stated that the recruitment problems faced by NHS organisations is due to a shortage of supply and *“these problems cannot be resolved by or have been caused by levels of pay”* (NHS Employers, 2015).
- 5.37 It is also worth noting that supply is likely to be much more responsive to pay in the medium to longer-run than it is in the short-run, in part due to the fact that there is a qualifying process to be undertaken before anyone

can practice as a nurse. This means there is a risk that focusing solely on the short-term in the planning process leads to a downgrading of the importance of pay. In the medium to long run, it is vital that nurses' pay and conditions keep pace with those available in the other occupations that compete for labour with the nursing profession.

**(ii) Improving conditions**

- 5.38 If it is difficult to lure nurses back into the profession, then perhaps more could be done to reduce the likelihood of them leaving in the first place. The Department of Health said that a major issue in retaining nurses was the overall working conditions and poor image associated with the profession. The organisations that nurses work in were seen as becoming less stable in terms of their structures and leadership, leading to a poor working environment. There were fewer nurses looking after more patients, leading to increased stress and fatigue levels among nurses. This may encourage nurses to move to different roles or to reduce their hours. Other issues included the high proportion of nurses at retirement age and, as nursing is still a predominantly female workforce, a significant proportion leaving the profession or reducing their hours to look after children or become carers.
- 5.39 We did receive some, limited, evidence of initiatives that sought to improve retention rates including facilitation of internal transfers, secondments and training to give staff enhanced career development opportunities. A greater understanding of employment models, roles and responsibilities would help employers to provide better support and career progression pathways. Providing financial and other incentives such as accommodation, childcare and support for home caring responsibilities may also improve retention rates. In line with the above, it would be useful to gather more and better data on the reasons why people are leaving the profession. In the social care sector, training and courses specifically aimed at social care nursing and additional placements within the social care sector would likely be beneficial.

**(iii) Revalidation**

- 5.40 Revalidation is the new process, from April 2016, that all nurses and midwives in the UK will need to follow to maintain their registration with the NMC. It is intended to demonstrate that registered nurses practise safely and effectively. Nurses will have to revalidate every three years and the requirements for revalidation are:
- 450 practice hours, or 900 if renewing as both a nurse and midwife;
  - 35 hours of continuing professional development including 20 hours of participatory learning;
  - five pieces of practice-related feedback;
  - five written reflective accounts;

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- reflective discussion;
- health and character declaration;
- professional indemnity arrangement; and
- confirmation.

5.41 Although non-specific in their concerns, a number of partners told us they feared that some nurses would leave the profession rather than undergo the revalidation process. Therefore, revalidation may have a negative impact on nursing supply.

### (iv) Carter review

5.42 Lord Carter of Coles led a review of operational productivity in NHS providers and reported in February 2016. The review's early findings were that there were significant differences between hospitals in terms of the management of productive time, workforce rostering, effective utilisation of clinical time and management costs and that there was scope for efficiency savings. It may be, therefore, that NHS employers could do more to rationalise their deployment of nurses in order to alleviate shortages.

5.43 The Carter review's interim report expressed concern about the impact of inefficiencies on nurse supply which seems of relevance to our consideration of nursing shortages: *"All of this leads us to assume there may not be enough nurses to meet the post-Francis demands of the NHS"* (Lord Carter of Coles, 2015).

### (v) Other efficiency initiatives

5.44 Partners highlighted to us other efficiency initiatives aimed at improving effectiveness and productivity of existing nursing staff. These included:

- improving the skill mix to follow a multi-professional team design;
- making full use of allied health professionals and other roles including the potential introduction of a nursing role between Healthcare Support Worker and Registered Nurse (provisionally referred to as a nursing associate);
- Open University pilot programmes to attract students and which will allow eligible people to train to become a registered nurse while continuing to work in a relevant healthcare role;
- incentives to attract agency staff to substantive or bank employment; and
- improved graduate employment including Values Based Recruitment (which aims to attract and recruit students, trainees and employees on

the basis that their individual values and behaviours align with the values of the NHS Constitution) and course funding initiatives.

## 5.5 What other sources of nurses are there?

- 5.45 Partners were very much of the view that there are not enough UK nurses to fully serve the needs of the health and care sectors. Employers can recruit from within the EEA, so we looked to see whether EEA nurses alone were sufficient for the sectors' needs.
- 5.46 Chapter 2 looked at the changing pattern of nurse recruitment from within and outside of the EEA. Partners told us that this pattern may be changing again. NHS Employers said that there had been an increase in non-EEA recruitment from 2014, although this may not be apparent in Nursing and Midwifery Council (NMC) registration data until 2016. HCL Workforce Solutions (a recruitment company) told us they currently had supply contracts with trusts for around 2,100 nurses, with 63 per cent of these nurses coming from within the EEA and 37 per cent from outside. However, they anticipated bringing in another 2,300 nurses at a ratio of 36 per cent from the EEA and 64 per cent from outside. Another recruitment agency (TTM Healthcare) told us that the volume of EEA recruitment will drop because of local and international competition, as well as the introduction of more stringent English language testing (we discuss the latter below).
- 5.47 Partners told us that they had a preference for recruiting non-EEA nurses rather than those from within the EEA. They said that non-EEA nurses were well qualified, had better English language skills and were more likely to remain with their employer than nurses from within the EEA. They also said that there were now fewer suitable EEA candidates. We set out below some of the evidence we received on these issues.

### (i) Non-EEA nurses are well-qualified

- 5.48 Care provider Four Seasons told us that the majority of EEA nurses did not hold NMC recognised equivalent qualifications without undergoing an adaptation programme. Four Seasons therefore felt that they had little option but to recruit suitably qualified nurses from outside the EEA, if they could not source nurses within the UK. Lewisham and Greenwich NHS Trust told us that non-EEA nurses were well qualified and offered a better return on investment as these nurses tended to complete a minimum 3-year contract. North Tees and Hartlepool NHS Foundation Trust said that non-EEA nurses had a minimum of 1-year post-registration licensed practice.
- 5.49 The Department of Health said that nurses from non-EEA countries typically had more years of experience than their EEA counterparts, most of the latter being newly qualified, and that recruiting both from within the EEA and outside delivered a better balance of grades and experience than would EEA recruitment alone. Similarly, NHS Employers said that employers were recruiting more newly qualified nurses whereas a year or

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two earlier they were recruiting experienced nurses. NHS Employers also said that newly qualified nurses required a lot of support and were, therefore, not as attractive to an employer.

### **(ii) Non-EEA nurses have better English language skills**

- 5.50 The Department of Health, and many other partners, told us that the ability of employers to recruit migrant nurses is expected to further decline with the introduction to the nursing registration requirements of an increased standard of English language ability. Nurses' language skill is assessed by the International English Language Testing System (IELTS) and if nurses cannot provide evidence of their English language skills - such as having trained or worked in an English-speaking country – they need to pass the IELTS test at the requisite level. The level of pass was increased in January 2016 from band 6 to band 7.

*“The introduction of the new language training requirements for registrants from within the EU will further reduce the numbers of EU nurses wishing to come to the UK which will put even greater pressure on the need to recruit overseas nurses.”*

TTM response to MAC call for evidence

- 5.51 Partners told us that nurses from the Philippines and India tended to have better English skills and that this made them preferred candidates for recruitment. In Chapter 2, we highlighted that all of the top ten nationalities recruited by the health sector in recent years were from countries where English is either the national language or is widely spoken.

### **(iii) Non-EEA nurses remain longer with their employer**

- 5.52 It is the case that EEA nurses can switch employers as they desire, whereas non-EEA nurses have to remain employed by their sponsor for the duration of their visa or else obtain a new visa. It is perhaps not surprising, therefore, that employers tend to prefer employees that are tied to them in this way over free agents. And, because non-EEA nurses are nearly all from countries where nurse pay is much lower than the UK and a Tier 2 visa offers a path to settlement in the UK, they are much less likely to return home than an EEA nurse.
- 5.53 The Shelford Group told us that non-EEA nurses made a more attractive proposition when exploring international recruitment options, as EEA recruits were difficult to retain. A significant proportion of EEA recruits returned to their home countries within a matter of years, while non-EEA nurses were far more inclined to remain in their employment. They gave an example of one trust which had recruited in India in 2001-02 and 78 per cent of the staff hired were still employed in the trust in 2015.

**(iv) Fewer candidates within the EEA**

- 5.54 A number of partners reported to us that they were seeing fewer suitable candidates from within the EEA, because these nurses were not applying for jobs in the UK and/or because of increased competition from more UK employers seeking EEA nurses. The Shelford Group told us that many of their members had recruited from EEA countries such as Ireland, Spain and Portugal but that this supply had now reduced, both in terms of the numbers and the quality and spread of specialisms available.

**5.6 Are employers incentivised to recruit non-EEA nurses?**

- 5.55 While partners provided significant amounts of evidence on the desirability of recruiting non-EEA nurses over EEA nurses (some examples of which are highlighted above), they also gave reason for us to consider whether they did not also prefer non-EEA nurses over UK nurses. Although the upfront cost of recruiting from outside of the EEA is substantial (partners said that each non-EEA nurse can cost between £6,000 to £9,000 to recruit), it may be the case that long-term savings can be made if employers bring in experienced nurses and pay them at a lower rate than similarly skilled nurses from within the UK, or at lower rate than agency staff.
- 5.56 The National Audit Office (NAO) (National Audit Office, 2016) estimates that recruiting a migrant nurse costs between £2,000 and £12,000, recruiting a nurse via a return to practice scheme costs some £2,000 per nurse, while training a new nurse costs around £79,000. We described in Chapter 4 the NAO's view that trusts' workforce plans appear to be influenced as much by meeting efficiency targets as by staffing need.

*“The RCN believes that providers in England have heavily underestimated the number of pre-registration education commissions needed. We believe that this has been done in order to meet stringent financial goals. For the period 2010-2015, we estimate that this shortage has been in excess of 25,000 training places.”*

Royal College of Nursing response to MAC call for evidence

- 5.57 The Department of Health said in their evidence to our 2014–15 partial review of nurses in the health sector that *“there is evidence that the supply issues are caused by budgetary pressures and not a supply shortage”* (Department of Health response to MAC call for evidence in 2014). The fact that it may be cheaper, whether in the short or long run, to employ a non-EEA worker is not sufficient reason to pass our sensible test and we have, therefore, carefully considered the extent to which the evidence we have received points to a preference for non-EEA workers on grounds of cost.

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- 5.58 In meetings with partners, we were told that employers often looked to recruit non-EEA nurses with specific skill sets but that the pay on offer was nearly always the bottom of band 5. Recruitment agencies told us that employers were quite specific about the salaries that were to be offered to non-EEA nurses and that there was to be no variance from this irrespective of the skills that the nurse might offer. Some employers described being able to employ a more experienced nurse at the bottom of band 5 as a bonus. UNISON said that they have received reports of experienced Spanish nurses being recruited at low rates.

*“It is important, however, that the health service recruits migrant nurses on the same rates of pay and conditions as local workers. Often migrant nurses are recruited through agencies on lower rates of pay than permanent staff.”*

TUC response to MAC call for evidence

- 5.59 This is a controversial issue. Individual employers have strongly stressed to us that they are not using non-EEA migrants to undercut UK nurses and that their preference is very much for UK nurses. The major health and care sector organisations have also stressed that there is no attempt being made to undercut UK nurses and that migrant nurses can earn a higher salary through working extra and additional hours and that all nurses get paid according to the level of the work they do – so, if a nurse is doing the work of a higher band, he or she will be able to apply to be promoted to the higher band.
- 5.60 We accept what partners tell us and do not consider there to be a concerted attempt to undercut UK nurses. However, we have already highlighted in our Tier 2 report (Migration Advisory Committee, 2015b) that nursing is an occupation where, on average, migrants are paid £6,000 less than equivalent UK workers. We have re-examined our analysis on this issue in the light of discussions with the Department of Health and NHS Employers and find that our findings remain robust (see Annex B). Whether by accident or design, nursing is an occupation where migrants are on the whole paid less than UK staff unlike most other occupations under Tier 2 where migrants are generally paid more than UK staff.
- 5.61 This underlines why it is important that our recommendations in our Tier 2 report (Migration Advisory Committee, 2015b) relating to the salary thresholds and also to the immigration skills charge are implemented across the public sector as well as the private sector. Our Tier 2 recommendations are aimed at shifting the demand for Tier 2 workers along the skills – and pay – spectrum. The government should no more tolerate migrants working at lower rates of pay in the public sector than it does amongst private sector employers. Our recommendations to increase the minimum salary to £30,000 and to introduce a £1,000 per migrant per year immigration skills charge will ensure that employers will consider very carefully their need to recruit migrant nurses to perform

band 5 minimum duties as opposed to more specialised and more skilled roles.

## 5.7 Our overall assessment of sensible

5.62 Having considered above the evidence in relation to each of our four questions, we now consider whether there is sufficient cause to conclude that our sensible criteria have been met.

### (i) Issues with the data and evidence we received

5.63 We have a number of issues with the data we analysed and the evidence we received and we are surprised that these issues appear not to cause concern across the health and care sectors.

5.64 For example, earlier in this chapter we looked at whether we could identify the number of qualified nurses who were not presently employed in that profession. We ended up with two potential illustrative estimates that followed from our analyses of the available data. None of our partners appear to have attempted to identify the potential numbers of qualified nurses that could be encouraged to return to the profession.

5.65 In Chapter 3, we looked at vacancies in the health, care and independent sectors. We consider that the health sector's collection and interpretation of vacancy data, in particular, is sorely lacking. The NHS Jobs website (<http://www.jobs.nhs.uk/>) states that it is used by every NHS trust in England and Wales to advertise vacancies (although it does not say whether trusts are obliged to advertise on this website). The site claims that it carries between 20,000-25,000 jobs every month. It seems to us that this site offers a rich potential resource to the health sector of live information on health vacancies. We accept that there are some issues with the data that could be generated but suggest that requiring each advertiser to state how many posts they are advertising for would address a lot of these. We are surprised that the health sector does not show more enthusiasm for interrogating this resource and using it to inform their workforce planning.

5.66 The data and evidence we received pointed most strongly to shortages of nurses in England. There was not separate evidence of similar shortages across the whole of each of the devolved administrations (although there were examples of local pockets of shortage). Notwithstanding the arrangements relating to devolution, the health and care sectors show insufficient curiosity about why the situation in England is so different to that in Scotland, Wales and Northern Ireland.

5.67 NHS Improvement, which from April 2016 brings together Monitor, the NHS Trust Development Authority plus groups from NHS England, NHS Interim Management and Support and the National Reporting and Learning System, has published a report (NHS Improvement, 2016) looking at the impact of a rise in demand for clinical staff. The report found that, since the end of 2012, there had been a large increase in demand for

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hospital nurses across the NHS. In 2014, providers reported to HEE that they needed 189,000 adult nurses, whereas two years earlier they predicted they would need only 165,000, and, as seen in this report, demand continues to outstrip supply.

- 5.68 One factor cited by NHS Improvement as contributing to this supply gap is a drop in recruitment of nurses from outside the EEA. We looked, in Chapter 2, at the decline in non-EEA recruitment. This decline aligns with what the government wants to see happen across the UK economy, with employers becoming less reliant on non-EEA migrants and increasing investment in training and upskilling UK workers. However, in this particular case there has not been an increase in investment as the number of training places was cut: *“Between 2010/11 and 2012/13 the number of nursing training places fell by 12.7% from 20,092 to 17,546”* (NHS Improvement, 2016).
- 5.69 Demand, meanwhile, has been increasing due to a range of factors including an ageing population, better treatments, and increased emphasis on safe staffing levels. Employers have had to look to other sources, basically a combination of nurses from within the EEA and agency nurses. In the case of use of agency nurses, the issue was not one of shortage but one of cost. Pay for agency nurses has increased while Agenda for Change pay has fallen in real terms: *“To meet their rising demand for nurses, providers have turned increasingly to agency staff...we estimate that around £0.7 billion is the premium paid for agency staff over the equivalent substantive pay and on-costs that providers would incur”* (NHS Improvement, 2016).
- 5.70 Retention of nurses by the NHS and the care sector becomes increasingly difficult the wider the wage gap between agency nurses and the rest. A lot of the evidence we received highlighting difficulty in recruitment is really about this issue: employers find it hard to attract and retain the permanent staff at the wages they are offering, but the consequence of that, in many cases, is that they source an agency nurse to do the work. The issue here is not one of shortage per se, in that a nurse still ends up doing the work. It is really about cost.
- 5.71 However, the supply of EEA nurses is drying up and agency nurses are expensive and have now been price capped. The removal of bursaries could lead to an increase in the numbers of UK nurses being trained but the impact of this will not be felt for at least three years. Employers faced with increasing demand are, therefore, now looking to increase their intake of nurses from outside the EEA. We will look later on at the potential impact this could have on the ability of other employers to access the Tier 2 route and will focus here on the impact on the UK labour market.
- 5.72 We were told by Department of Health that employers in England will look to recruit some 11,000 non-EEA nurses over the next four years. The evidence suggests that significant numbers of these nurses could be recruited at the minimum band 5 level salary, irrespective of their actual level of skill and experience. The influx of large numbers of, relatively,

experienced (certainly more experienced than new graduate) nurses at the lowest salary level will act to continue to suppress the wages of nurses across the UK labour market, and will not help make nursing a more attractive career option than alternative occupations. Under these circumstances alone, we would be hard put to recommend that nurses remain on the SOL.

- 5.73 However, although we strive to treat occupations the same and give them the same emphasis in our considerations, it does remain the case that, in the short-term at least, a shortage of nurses can inflict more direct and immediate suffering on the UK population than shortages of other occupations outside of the health and care sectors. We therefore looked at whether there were credible, realistic plans to reduce reliance on migrant nurses and how long these might take to have full impact.

**(ii) Assessment of plans to address nursing shortages**

- 5.74 The Department of Health told us that current and planned initiatives should, if successful, drive supply above demand for the NHS nurse workforce by 2019. We do not have access to supporting evidence in order to assess how achievable these reductions in demand and gains in supply are. And to an extent, that is not our job. We note that there is a quantified programme of initiatives underway to address these issues. However, we do note that there is nothing in these measures, which seems to address the issues of nurse supply and demand in the independent and care sectors. We noted in Chapter 4 that insufficient attention paid to demand in the care and independent sectors had built in a structural undersupply of nurses.
- 5.75 HEE, like the Department of Health, say that NHS trust demand for staff can be met from within the UK by 2019. However, as we have said, the figures cited do not appear to factor in demand from the care sector and do not present detailed workings on which to base an assessment of their viability. The NHS does not have a great track record in predicting staffing demand and supply.

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*“The demand modelling undertaken to inform student nurse commissions is not robust or wide enough to predict demands for the UK, as it excludes independent health care providers, health and social care staff, and voluntary sectors, from workforce planning. The increased focus on integrated healthcare models as a healthcare delivery system is not aligned to the demand modelling workforce planning for this, hence there are insufficient registered nurses to deliver whole system healthcare.”*

Shelford Group response to MAC call for evidence

### **(iii) What we were told in previous reviews of nursing**

- 5.76 In 2014, we were asked by the government to conduct a partial review of the SOL focussing on a small number of occupations including graduate occupations within the health sector. The Centre for Workforce Intelligence (CfWI) sent us, in December 2014, evidence on behalf of the Department of Health and Health Education England, building on previous CfWI submissions to the MAC in 2011 and 2012. The CfWI gathered evidence from healthcare providers in response to the MAC call for evidence, and analysed this in conjunction with its own secondary research.
- 5.77 In relation to adult nurses, the CfWI evidence said that many employers reported being under pressure to fill vacancies with a number of organisations and trusts reporting nurse shortages. The evidence also recognised that there is no accurate national vacancy data for adult nurses and that, while there has been an overall nursing workforce growth between 2009 and 2013, adult nurses working in the NHS are currently not specifically counted and recorded, and that, therefore, it would be sensible to establish both better recording and a better understanding of this workforce for the next SOL review. The variety of data we received in the course of this review suggests that this CfWI suggestion has yet to bear fruit.
- 5.78 The CfWI and Department of Health concluded that it would not be sensible to recommend adult nurses for inclusion on the SOL because:
- The evidence was that the shortage of nurses is employer-driven, rather than structural.
  - As much as 96 per cent of all recruitment activity for Band 5 nursing roles took place in the EEA, particularly from Spain, Ireland and Portugal and also from Italy and Romania.
  - Evidence from the NMC and Home Office showed that non-EEA recruitment was relatively small compared to both EEA recruitment and the total size of the nursing workforce.

- There was evidence that the supply issues are caused by budgetary pressures and not a supply shortage.
- A number of existing programmes and proposals were in place designed to address recruitment issues.

5.79 In September 2015, we received evidence from CfWI on behalf of the Department of Health in response to our Tier 2 call for evidence which included an update on nurses further to their earlier SOL submission. This update expanded the CfWI commission from the Department to include adult social care nursing as well as NHS nursing occupations. It concluded that, after updating and reassessing the evidence on nursing occupations, there was sufficient evidence to justify nominating adult nurses and four other nursing specialties for inclusion on the SOL.

5.80 The reasons for making this different recommendation were as follows:

- Although as much as 96 per cent of all international recruitment activity for Band 5 nursing roles took place in the EEA, organisations reported to NHS Employers their plans to attempt to recruit from many countries outside the EEA.
- Evidence from the NMC suggested that there is a viable supply of nurses outside of the EEA that are registering to work in the UK, although the non-EEA intake had decreased from 2013-14 to 2014-15.
- A number of existing programmes and proposals were in place to address recruitment issues but there was an immediate demand to fill shortages as evidenced by employers spending large amounts on agency nurses.
- Including nurses on the SOL would help alleviate nurse shortages while other measures took effect.
- The evidence that stated that there was a shortage of adult nurses in social care.

**(iv) Potential impact on allocation of certificates of sponsorship of retaining nurses on SOL**

5.81 The latest figures on numbers of applications for certificates of sponsorship (CoS) indicate a significant spike in applications from NHS employers, as shown in Table 5.5.

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**Table 5.5: Volumes of CoS applications - NHS versus non-NHS**

	NHS	Non-NHS	Grand Total
2012-13	96	952	1,048
2013-14	600	1,181	1,781
2014-15	2,658	1,321	3,979
2015-16 (to Jan)	5,280	1,400	6,680
<b>Total</b>	<b>8,634</b>	<b>4,854</b>	<b>13,488</b>

Source: Home Office MI, April 2012- March 2016

- 5.82 The increase in applications from the NHS has grown exponentially in recent years: already in 2015 (so far) the volume of applications is twice that for the whole of 2014-15. By contrast the growth in applications for non-NHS has been much slower. In the current financial year, the NHS accounts for almost 4/5 of all nurse applications.
- 5.83 The monthly limit on allocations of CoS was reached each month from June to November 2015, although since then the limit has been undersubscribed. The Department of Health indicated to us that they anticipate a total of some 11,000 non-EEA nurses within England being brought in across the next four years, with demand front-loaded so that larger numbers were recruited in the early years and then declining. Scaling up to include the devolved administrations, the total number could be over 14,000. Clearly, when CoS are scarce, having a large number of requests for a single occupation will impact on employers seeking to recruit other occupations under Tier 2 (General). If the monthly limit binds again, these other employers may find their CoS applications refused. This will be a potential loss to the UK economy and employers may feel rightly aggrieved that while they have made every attempt to seek a UK workforce, they still end up in this position because the health sector has mismanaged the training, pay and conditions of its own prospective workforce. In the next chapter, we propose some ways of tackling this issue.

### **(v) Has the sensible criteria been met?**

- 5.84 We are not convinced that the health and care sectors are employing non-EEA nurses at the lowest possible rates for reasons other than to save money. The health sector controls its own supply of nurses through training commissions and yet has managed to leave itself without sufficient nurses. There are plans to tackle issues of recruitment and retention but the lack of detail in the material we have seen makes us wonder whether these are aspirational rather than guaranteeing delivery. The sectors have, in our opinion, an unrealistic view that the role of pay in recruitment and retention is only weak.
- 5.85 Ultimately, it comes down to cost. It has been the desire to cut costs and to save money that has left the sectors reliant on non-EEA nurses to fill staffing shortfalls. We have real concerns that these non-EEA nurses are employed because they are a cheaper option.

- 5.86 Further, we think that there is a real risk that if nurses remain on the SOL, without further incentive for the health, care and independent sectors to tackle shortages, then the situation may not be any better in 2019 than it is now. Indeed, retaining nurses on the SOL could be seen as a reward for bad practice.
- 5.87 We also note the views of the Department of Health and Health Education England that the UK will have achieved a demand/supply equilibrium of nurses by 2019–20. Given the track record of the health and care sectors in predicting and delivering an adequate supply of nurses, we treat this with some scepticism. We, therefore, do not think it appropriate to suggest that nurses, if they are retained on the SOL, be automatically removed in 2020. But we do think it would be sensible to review before then whether they should be retained on the SOL. Nobody knows what will happen to the numbers of training places and prospective students once bursaries are removed. We understand a public consultation is forthcoming on the detail of removing bursaries. This ought to include detailed appraisal of the impacts on student nurse numbers. So far, the Government has cited a figure of an additional 10,000 nurses undertaking degrees, but at this stage this seems more of an aspiration than the result of rigorous analysis. Moreover, HEE have not made any assumptions in their plans about the impact on the removal of bursaries on future supply of nurses. HEE's plans contain caveats to the effect that they are reliant upon other factors such as health employers improving the retention and return to practice rates.
- 5.88 As we intimated at the outset of this section, if we were looking at almost any other occupation than nurses, we would find it easy to conclude that our sensible criteria were not met. In which case, we would suggest to the employers that they go and increase the number of training places to meet capacity and increase staff pay to reduce the numbers leaving the profession.
- 5.89 In fact, we do say this to the employers, and, in this case, to the Government. There is no good reason why the supply of nurses cannot be sourced domestically. The long-term solution to nursing supply is to offer people sufficient incentive and opportunity.
- 5.90 However, we are asked to consider the short term in making our recommendations. Assuming that the optimistic aspirations of HEE and the Department of Health do bear fruit in relation to the future number of graduate nurses, these will still not come on stream until 2019 at the earliest. We would like to see more being done to improve recruitment and retention but, in the absence of an improved pay offer, consider that the numbers returning to the profession are likely to remain low while those in the NHS and care homes will continue to be encouraged to leave and find better remunerated work elsewhere, whether for agencies or in another occupation altogether.
- 5.91 Under these circumstances, the alternative options to addressing the short-term supply of nurses are therefore limited. Given the risks to the

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safety and care of patients that could result from an insufficient number of nurses, it becomes a case of not is it sensible to retain nurses on the SOL but is it sensible not to.

## Chapter 6: Summary and recommendations

### 6.1 Summary of the report

#### MAC commission

- 6.1 The Home Secretary placed the whole of the nurse standard occupational classification (SOC) code on the shortage occupation list (SOL) in October 2015 and at the same time wrote to the MAC asking that we review whether nurses should remain on the SOL.
- 6.2 We issued a call for evidence and held meetings and visits with a number of key partners from national bodies to local trusts within the health, care and independent provider sectors. We had previously reviewed nurses on the SOL in 2014-15 (when we recommended that they should not be added to the list) and we told partners that we would draw upon the evidence they provided in response to that review and also to our Tier 2 review last year.
- 6.3 Health is a devolved issue and there are separate arrangements governing healthcare provision in England, Scotland, Wales and Northern Ireland. However, it is a requirement from the government that an occupation recommended for inclusion on the SOL must be in national shortage (i.e. in shortage across the whole of the UK). The exception to this is Scotland, which has its own shortage list, and occupations for inclusion on this list need only be in shortage in Scotland.

#### Size of the nursing occupation

- 6.4 We looked to see how many registered nurses are presently employed as nurses in the UK. There are a number of different data sources for this and our best estimate is that there are around 630,000 qualified nurses working in the UK, of which some 500,000 work in the NHS.
- 6.5 The OECD estimated that in 2011, at least a fifth of these were nurses from overseas. On this basis, we believe that there are of the order of 140,000 foreign-born qualified nurses registered to practice in the UK.

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6.6 Over the last 25 years, immigration of foreign-born nurses to the UK has at times been a significant contributor to overall nursing supply. Annual inflows peaked at just over 16,000 in 2001/02, having been below 5,000 a year during most of the 1990s. Nurse inflows remained above 10,000 each year up to and including 2005/06, before falling to over 2,000 in 2009/10. Numbers have again risen to around 8,000 in 2014/15 with the vast majority of these have been from the EEA.

### MAC methodology for assessing shortage

6.7 The MAC has an established methodology for determining whether to recommend an occupation for inclusion on the SOL and we used this methodology in looking at nurses. We have three tests:

- Is the occupation skilled to the requisite level (in this case, level NQF6+)?
- Is the occupation in shortage across the UK?
- Is it sensible to bring workers from outside the EEA into the occupation?

6.8 In relation to skill, nursing is a graduate-entry occupation and so clearly meets the NQF6+ standard.

### Are nurses in shortage?

6.9 In relation to shortage, we have 10 available indicators of shortage. We used national level data from the Labour Force Survey and other sources to produce these indicators, which examine changes in pay, employment and the vacancy situation in the occupation. Three of the indicators relate to changes in pay. As nurses' pay in the NHS is subject to national settlements, and to an imposed pay restriction since 2010, we did not consider that the pay indicators were relevant to a consideration of nurses, due to the lack of wage responsiveness that would normally be expected to reflect a shortage. Excluding these pay indicators, nurses passed 5 out of the remaining 7 indicators of shortage. This is a strong pointer to nurses being in national shortage.

6.10 We examined other data to see how vacancies in nursing compared with vacancies in other occupations and these data also indicated that nursing had among the highest rate of vacancies. For the NHS, we looked at the available vacancy data for NHS nurses in England overall and then specifically for London, and then for each of the devolved administrations. Vacancy data for individual NHS trusts in England and Wales, as well as vacancy data for the care and independent sectors broken down at a regional level, was, unfortunately, not available to any reasonable extent. There was excellent vacancy data for NHS trusts in Northern Ireland and Scotland. We therefore compiled a picture of vacancies from the best available sources. This picture did not reconcile itself into a final number as there were too many variables in the data considered but the data did indicate that, in all cases, there were a higher number of vacancies in England than recommended in guidelines produced by the National

Institute for Health and Care Excellence (NICE). NICE recommend that organisations should aim for a maximum of 5 per cent vacancy rate to accommodate operational flexibility and data indicates that present vacancy rates average around 9 – 10 per cent.

- 6.11 Data obtained by the Royal College of Nursing indicated that trusts in London were running at around 17 per cent vacancies with significant variation between trusts of 3 per cent and up to 30 per cent vacancies. Overall, the average vacancy rate across London appeared to be a lot higher than any of the vacancy rates for England, and the data showed a significant variation in vacancy rates among trusts in London. We found in Chapter 2 that London and the South East accounted for around two-thirds or more of all nurse certificates of sponsorship used since 2013, which is proportionately well above those regions' share of total UK employment at 25 per cent. Both Scotland and Northern Ireland, meanwhile, indicated a vacancy rate just shy of 4 per cent, with a slightly higher rate being indicated across Wales.
- 6.12 NHS trusts in each of the three devolved administrations had an average vacancy rate lower than that for England which was, in turn, substantially lower than that in London. The composition of the national shortage, therefore, varies significantly across the UK as a whole. But the lion's share falls within England.
- 6.13 We did not find any national statistics in relation to vacancies in the non-NHS nursing sector. Skills for Care utilise the National Minimum Data Set for Social Care, an online workforce data collection system for the care sector. This data set indicated that the vacancy rate for nurses in social care was 7.6 per cent as of September 2014. BUPA reported a vacancy rate of 13 per cent for nurses nationally across the UK. A survey by Care England of its members indicated that all were struggling to recruit nurses with an average vacancy duration of 10 months.
- 6.14 Overall, the vacancy data available for the care and independent sectors is less robust than that for the NHS but what data there are indicate a level of shortage not dissimilar to that of the NHS.
- 6.15 We also received a lot of evidence from partners about the difficulties they were having in recruiting staff and how they were coping with the vacancies they were carrying. Although this evidence was self-selecting, with only one partner reporting no shortages, there was a consistency to what we were told. The fact that we received evidence of shortages in rural and urban areas, in large cities and smaller towns and villages, as well as in each of the devolved administrations, we took as indicating a UK wide shortage.

### **Are there shortages in specialties or across the whole occupation?**

- 6.16 We asked partners whether nursing shortages were across nursing as a whole or whether there were specific shortages in some nursing specialties. The standard occupation classification system coding for

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nurses (SOC 2231) breaks down into a high level range of different job titles as follows:

- District nurse.
- Health visitor.
- Mental health practitioner.
- Psychiatric nurse.
- Nurse.
- Practice nurse.
- Staff nurse.
- Student nurse.

6.17 This high-level range then breaks down further into 70 different job titles. Meanwhile, the Nursing and Midwifery Council recognises four fields of practice for registered nurses:

- Adult nursing.
- Mental health nursing.
- Learning disabilities nursing.
- Children's nursing.

6.18 Most partner evidence specified the field of adult nursing as being most in need of nurses from outside of the EEA. Within each of these fields, nurses can specialise in particular areas of nursing practice. Partners told us that a number of specialty areas were also experiencing shortage in addition to shortage across the broader field of nurses. Nursing specialities that were identified as being in shortage included neonatal nurses, theatre nurses and paediatric intensive care nurses.

### Why are there not enough nurses?

6.19 We then looked at reasons why there were presently not enough nurses, and the factors that affect the demand and supply for this occupation. We found that, on the demand side, an increase in the numbers of older people, changes to healthcare and the role of nurses, along with changes to safe staffing guidelines were having an impact. On the supply side, workforce planning and the number of training places, constraints on the recruitment of non-EEA nurses, and failure to retain sufficient numbers of nurses within the profession were the factors with most impact.

6.20 With the help of partners, we identified a number of reasons why sufficient numbers of nurses were not being retained within the profession. Partners

told us that working conditions were often cited as reasons by those leaving the profession. Factors impinging on this included stress, burnout, lack of job satisfaction and work environment. The nurse workforce was disproportionately concentrated at, or near, to the minimum age at which staff could retire and many staff were choosing to take this option. A number of nurses were choosing to work as nurses outside of the UK.

- 6.21 A wide range of partners expressed dissatisfaction with workforce planning across the health and care sector, concerns echoed by the NAO in a recent report investigating the supply of clinical staff to the NHS in England. At least some of the current shortage can be attributed to a decision to cut training places in 2010/11. Some evidence we received indicated that the numbers of training commissions funded in recent years have been driven more by financial pressures rather than anticipated demand. Additionally, until recently there has been little co-ordination of workforce planning across the care and independent sectors, with government funded training places designed to deliver only sufficient nurses to satisfy NHS demand. This has contributed to a structural undersupply of nurses in the UK.

### Nurses' pay

- 6.22 We looked separately at whether pay was a significant factor in nurses' decisions to leave the profession. Nurses' pay is set by the NHS Pay Review Bodies who operate currently with the Government's restriction of no more than 1 per cent growth in public sector salaries up to 2020. Nurses' pay grew strongly in the years up to 2010, since when it has been falling in real terms.
- 6.23 Nurses' pay in the NHS is bound by the Agenda for Change (AfC) pay bands. AfC also provides for supplements worth up to 20 per cent of basic pay for those working in high cost areas (mainly in and around London). There is also some flexibility to vary pay to address local shortages but we were told that these flexibilities were not widely exercised.
- 6.24 Pay for nurses in the care and independent sectors is not restricted to follow the Agenda for Change bands, and we did receive some evidence that pay has increased modestly in the care sector over the past year. Care services are, in many cases, purchased by public sector bodies at set rates and therefore partners in the care sector told us that they have limited ability to raise prices in order to fund pay increases. The care sector was often in direct competition for nurses with the NHS and the latter could often offer better terms and conditions, better career development opportunities and better pensions.
- 6.25 One area that could offer higher pay for nurses was agency work. Although we did not have direct data on pay in agencies, there was evidence to suggest that this had been increasing. We were told that NHS spend on agency nurses could amount to £980 million by the end of 2014/15. Monitor, the sector regulator for health services in England, has recently introduced caps to limit the rates NHS trusts can pay to agency

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workers as a proportion of Agenda for Change pay scales. Care providers were also being hit by charges for agency nurses and were not in a position to impose a cap similar to the NHS.

- 6.26 NHS hospital nurses in the UK are, on average, paid significantly less than hospital nurses in Australia, the USA and Ireland. These countries are the main destination countries for UK registered nurses who go to work as nurses overseas. Taking account of the factors that influence nurses' decisions to leave the profession, as well as the factors that impact on the demand and supply of nurses we then looked at whether it was sensible for employers to recruit nurses from outside the EEA.

### Is it sensible to recruit nurses from outside the EEA?

- 6.27 Having determined that there is currently a shortage of nurses in the UK, we then assessed whether or not there is a continued need for recruitment of non-EEA nurses. To help determine this, we identified four questions that would help us determine our final recommendations to the government. These were:
- Is there an underused UK supply of nurses which could help to address the shortage?
  - Would training more nurses have an impact on the numbers of non-EEA nurses coming to the UK?
  - What is the role of improvements in pay and conditions?
  - What other sources of nurses are there?
- 6.28 In relation to the first question, we found that approximately 80-90 per cent of persons in the UK who could be working as nurses were doing so. Partners told us of a number of schemes to encourage those who had left the profession to return to practice but these schemes were not generating large numbers of returnees.
- 6.29 For the second question, we looked at the plans to train more nurses. The Department of Health and HEE anticipate that the UK will be self-sufficient in nurses by 2019. However, these forecasts do not include any calculation of the possible effect of the removal of bursaries and are predicated upon improved retention rates.
- 6.30 One thing that can have a major impact on retention rates is improvements in pay and conditions, as specified in our third question. Employers across both the health and care sectors told us that they did not think that pay was a major factor in nurse recruitment and retention, while bemoaning the loss of nurses to agencies in pursuit of improved pay and/or working conditions. Overall, we felt that employers were too quick to dismiss the potential impact of improved pay and conditions on recruitment and retention.

- 6.31 Our fourth question looked at the alternatives to recruiting non-EEA nurses. Partners gave us several reasons why they preferred these nurses to those from within the EEA. The former were well qualified, had better English language skills, and tended to remain longer with their employers. We were told that there were now fewer suitable candidates from within the EEA.

### **Are employers recruiting non-EEA nurses because they are the cheapest option?**

- 6.32 Our consideration of these questions, plus other issues raised in the rest of this report, led us to consider whether employers were being incentivised to recruit non-EEA nurses in preference to other options. The National Audit Office estimates that recruiting a migrant nurse costs between £2,000 and £12,000, recruiting a nurse via a return to practice scheme costs some £2,000 per nurse, while training a new nurse costs around £79,000.
- 6.33 Home Office management information (MI) data show that non-EEA nurses were very often recruited at the lowest point on the Band 5 Agenda for Change scale, irrespective of the level of knowledge and experience they possessed. The data also highlights that newly employed non-EEA nurses are paid at exactly the same rate regardless of age. Clearly there is not always a perfect correlation with experience, but one might expect base salary to increase in line with age (see Annex B). Nursing is an occupation where, on average, migrants are paid £6,000 less than equivalent UK workers. Some of this difference will no doubt be due to the fact that the Home Office MI data do not include payments for unsocial hours. However, the lack of variation in base pay for newly arrived non-EEA nurses remains an anomaly.
- 6.34 We found that there was an historical aspect to the recruitment of non-EEA nurses being used to address shortages. We are concerned that there is evidence to suggest that non-EEA nurses are being used to mask systemic issues with workforce planning and are also being used to deliver savings to the employer rather than to address shortages that cannot be met through other means. In effect, employers are using non-EEA nurses as their Get Out Of Jail Free card rather than instituting long-term measures to guarantee future nurse supply.
- 6.35 However, the extent of present shortages and that fact that these cannot be remedied by other means in the short-term, lead us to make the following recommendations.

## **6.2 Our recommendations**

- 6.36 **Although the data and evidence are far from perfect, it does appear that there is currently a shortage of nurses in the UK.** Much of this evidence points towards the shortage being most significant in England, and having a lower impact in Scotland, Wales and Northern Ireland. Our

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remit is to consider whether there is a UK-wide shortage and, in this instance, on balance, we conclude that there is.

- 6.37 We were asked to review the whole of the nurse SOC code (SOC 2231). We received evidence primarily in relation to adult nurses. We did not receive much evidence relating to the other three nursing fields within SOC 2231, but we did receive evidence relating to some nursing specialties falling within these fields (such as neonatal nurses falling within the children's nurse field) as well as specialties falling within the adult nurse and mental health fields. Partners told us that the primary need was for adult nurses. These could be retrained in other specialties if needed, or more likely would be used to backfill for existing nurses being retrained in these specialties. However, we do have concerns that limiting the nurse presence on the SOL to adult nurses only would mean that other important specialties such as neonatal nurses would not be able to benefit from access to the SOL.
- 6.38 The majority of the data and evidence we received related to NHS employment of nurses rather than their employment in the care and independent sectors. We understand the reasons for this and, while we have concerns about the nature and extent of the NHS data which we have outlined in this report, we have looked closely at the evidence from the care and independent sectors to see to what extent this mirrors and to what extent it contradicts the evidence from the NHS. Broadly speaking, we have found a consistency in the evidence and the views put forward across all three sectors.
- 6.39 Having determined that SOC 2231 was skilled and in shortage, we then looked at whether our sensible test was passed. It is clear to us that the current shortage of nurses is largely of the health, care and independent sectors' own making. The sectors failed to train enough nurses or failed to make provision to train their own nurses should the supply of publicly funded nurses fail. They have taken either no or insufficient account of the needs of other sectors when making their planning assumptions. They restricted pay growth. They have complex institutional structures, which blur the decision-making process and lead, amongst other things, to poor information and data making it difficult for them (and us) to understand and respond meaningfully to labour shortages. They did not learn the lessons from the late 1990s/early 2000s when a similar shortage (and reliance on foreign nurses) occurred. Almost all of these issues relate to, and are caused by, a desire to save money. But this is a choice, not a fixed fact. The Government could invest more resource if it wanted to.
- 6.40 However, on sensible our decision and recommendation is based on immediate need. None of the alternatives to remedy the situation are quick fixes. With some reluctance, therefore, we believe it is sensible in the short-term to retain the whole of SOC 2231 on the SOL. **We therefore recommend that SOC 2231 (nurses) be retained on the shortage occupation list.**

- 6.41 However, as we highlighted in our recent Tier 2 review, such decisions imply policy trade-offs. The government has committed to an absolute ceiling of 20,700 places each year for the Tier 2 (General) route. Allowing non-EEA nurses unrestricted access to restricted certificates of sponsorship risks displacing other occupations that use the route (such as engineers). In 2015, there were 1,400 nurses who came into the UK under this route – representing 5.4 per cent of the total. We have a concern that these numbers could rise significantly based on the strength of the partner evidence response (in the early 2000s data suggest up to 15,000 non-EEA nurses a year came to the UK – if repeated this would immediately swallow up three-quarters of the Tier 2 allocation, at the expense, and to the concern, of other, mostly non-healthcare, employers).
- 6.42 The Government may wish to monitor the allocation of CoS in relation to nurses and to consider whether to have a monthly or an annual limit specifically for this occupation in order to avoid the scenario raised above. We suggest an overall annual ceiling for nurses of 3,000-5,000 places in the first year. This might then decrease year on year in line with the estimated needs set out by the health sector such that nurses would come off the SOL altogether by 2019, the point at which the Department of Health forecasts nursing demand and supply will return to equilibrium.
- 6.43 The industry itself could be tasked with prioritising applications under such a limit – for example the Department for Health could take on such a role for the NHS in England. Equally, the allocation of CoS under such a limit would need to be co-ordinated across the care and independent sectors, as well as for the devolved administrations too. We accept that it may be administratively burdensome for the health sector to manage and effectively ration available Tier 2 visas. However, we do consider that the sector itself should bear most of the responsibility for the current situation. Furthermore, it is important to fully consider the risks other users of Tier 2 (General) face in allowing employers of nurses to benefit from the SOL route.
- 6.44 Inclusion on the SOL means that employers do not have to conduct a resident labour market test (RLMT) for those occupations or job titles. Nurse employers told us that they would only recruit non-EEA nurses as a last resort having failed to recruit within the UK and the EEA. However, the RLMT ensures that employers have effectively tested the labour market before recruiting from outside the EEA. Applying an RLMT, even if they are on the SOL, could help to ease concerns that employers are recruiting non-EEA nurses in part to undercut native nurses. We were not asked to review the mechanisms within Tier 2 therefore do not consider this further here. However, the Government may wish to consider whether, in the context of nurses, an RLMT should still be applied even whilst on the SOL as a special case.
- 6.45 We have raised concerns above about whether the health and care sectors will be sufficiently incentivised to tackle nursing shortages if this occupation is retained on the SOL. The elements of unpredictability that appear built into their plans combined with their poor track record

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increases our concern that the position in 2019 may be much like it is now. If it wishes, therefore, it seems to us that the Government could then decide to remove nurses from the SOL on sensible grounds.

- 6.46 We conclude with yet another comment on the poor quality data being generated across the health and care sectors in relation to areas where there should be a rich source of information. We will be happy to review nurses again in two to three years time, should the Government commission us to do so, and we trust that by then the sectors will be able to supply accurate, uniform and comprehensive data on their own staff.

## Annex A: Consultation

### **A.1 List of organisations that responded to the call for evidence who did not request anonymity**

Apex Care Homes Ltd.

Aspen House Care Home

Barchester Health Care

Barking, Havering & Redbridge Hospitals NHS Trust

Basildon and Thurrock University Hospitals NHS Foundation Trust

Beechill Nursing Home

Biltonhall Nursing Home

Bliss

Bupa UK

Care Association Alliance

Care England

Care Inspectorate

CareConcepts

Central Manchester University Hospitals NHS Foundation Trust

Department of Health

Four Seasons Health Care

Fresenius Medical Care (UK) Ltd

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Hampshire Hospitals NHS Foundation Trust

HCL Workforce Solutions

Health Education England

Hospital of St John & St Elizabeth

Kent Community Health NHS Foundation Trust

Lancashire Care Association

Lewisham and Greenwich NHS Trust

Macklin Group

MD Healthcare Ltd

Methodist Homes (MHA)

Minister for Health, Social Service and Public Safety, Northern Ireland

Monitor and NHS Trust Development Authority

New Century Care Limited

NHS Employers

NHS England

NHS Greater Glasgow and Clyde

NHS Providers

NHS Wales Employers

Northern Devon Healthcare Trust

North Tees and Hartlepool NHS Foundation Trust

P J Care

Recruitment & Employment Confederation

Registered Nursing Home Association

Royal College of Nursing

Royal College of Paediatrics and Child Health

Royal Surrey County Hospital NHS Foundation Trust

Scottish Care

Scottish Government Health and Social Care, Health Workforce

Scottish Social Services Council

Sheffield Teaching Hospitals NHS Foundation Trust

Shelford Group Chief Nurses

Skills for Care

Springhill Care Group

The Children's Trust

The Orders of St John Care Trust

TTM Healthcare

Trades Union Congress

Unison

University Hospitals Birmingham NHS Foundation Trust

**A.2 Indicative list of some of the organisations with whom we had follow-up**

BOC Healthcare

BUPA

Burton Hospitals NHS Foundation Trust

Care England

Care UK

Central Manchester University NHS Foundation Trust

Centre for Workforce Intelligence

Circle Health

DAC Beachcroft LLP

Department of Health

Embrace Group

Four Seasons Health Care

Glenside Care

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Health Education England

HCL Workforce Solutions

NHS England

Nursing and Midwifery Council

Royal College of Nursing

Royal Stoke University Hospital

Shelford Group

Shrewsbury and Telford Hospital NHS Trust

The Pennine Acute Hospitals NHS Trust

TTM Healthcare

Unison

Western Sussex Hospitals NHS Foundation Trust

West Hertfordshire NHS Trust

## **Annex B: Analysis of the pay differential between Tier 2 migrants and the UK labour force**

### **B.1 Nurses' Pay**

- B.1 In our review of Tier 2 (Migration Advisory Committee, 2015b) we carried out regression analysis using Home Office management information and Annual Survey of Hours and Earnings (ASHE) data. Within this analysis, we estimated the average difference in pay for migrants compared with UK workers of the same age and working in the same occupation, distinguishing between workers in London and other regions of the UK.
- B.2 Our analysis suggested that, on average, Tier 2 (General) nurses are paid around £6,000 less than the average salary for UK workers of similar age in those professions. This appears to be because non-EEA nurses are often recruited at the base point of the relevant pay band within the Agenda for Change pay scale. This is irrespective of age and, by assumption, experience.
- B.3 We provide some illustrative analysis in Figure B.1 which shows several NHS trusts, both in and out of London, bringing non-EEA nurses to work in the UK under Tier 2 (General) and employing them at the bottom of the Agenda for Change pay scale for Band 5 nurses, regardless of the nurses' age. This pattern can be seen in the majority of the top 10 recruiting trusts who make up 68 per cent of all Certificates of Sponsorship for nurses under Tier 2.
- B.4 We have discussed this issue further with the Department of Health and NHS Employers, and invited both to submit further evidence and data to us that contradicts the findings of our analysis. Their responses were not satisfactory.
- B.5 We were told that most new nurse recruits enter at the bottom of Band 5 unless a trust has good reason to pay a higher rate. For a trust looking to save money, it seems to us that there may be a strong incentive to recruit a nurse from abroad at the bottom of Band 5 (who may be an experienced nurse) rather than recruit an experienced nurse from another trust at a higher salary. Whilst we sympathise with the pressure trusts are under to make savings, recruiting experienced non-EEA nurses at the bottom of the

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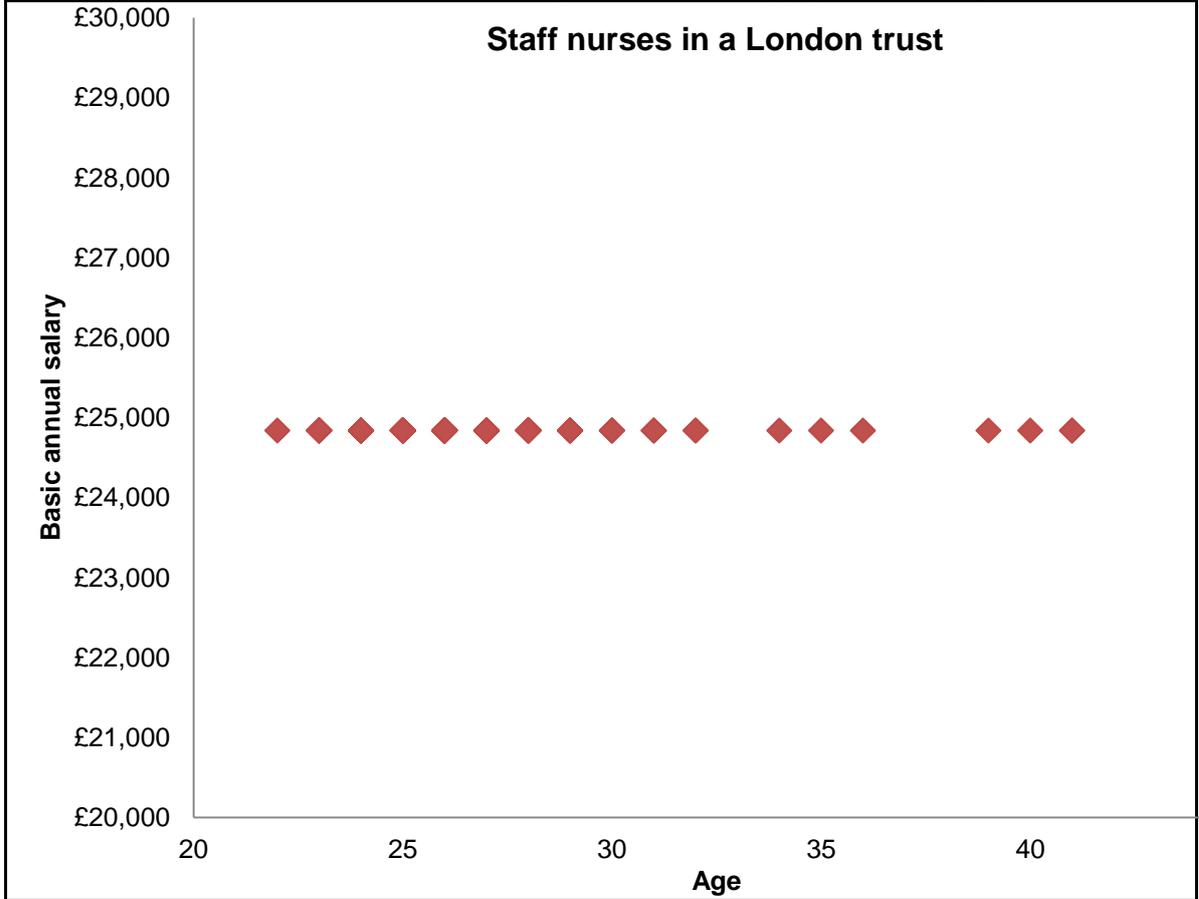
pay band undercuts existing UK nurses and acts to suppress pay across the occupation.

- B.6 We were also told that the basic annual salary provided on the Certificate of Sponsorship (CoS) form does not include any additional payments for the anti-social hours that nurses may work to cover a 24-hour, 7-day week rota. We acknowledge that a comparison between ASHE data and CoS data on pay may not be an exact like-for-like match, as ASHE does include anti-social hours. However, no alternative data sources have been presented to us as a better measure. We have excluded from Table B.1 any overtime payments contained in ASHE and this leads to a £3,900 differential between non-EEA nurses and their UK equivalents working within the NHS. Table B.1 shows that, regardless of the different specifications you use, there is still a significant wage differential for non-EEA nurses compared to their UK equivalents. Please see Annex C of Migration Advisory Committee (2015b) for full details of the regression analysis undertaken.

**Figure B.1: Basic annual salary by age for Tier 2 nurses recruited to a selection of NHS trusts, CoS Used (out-of-country), year ending March 2015**



Figure B.1: Basic annual salary by age for Tier 2 nurses recruited to a selection of NHS trusts, CoS Used (out-of-country), year ending March 2015



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**Figure B.1: Basic annual salary by age for Tier 2 nurses recruited to a selection of NHS trusts, CoS Used (out-of-country), year ending March 2015**



**Table B.1 Further regression analysis on the wage differential between Tier 2 migrant and resident nurses.**

Wage restrictions*	NHS only	Private/care sector only	All nurses	London + SE only	Excluding London + SE	All regions	Compared to ASHE new hires	Excluding overtime pay	ASHE public sector only	Wage differential
			X			X				-£7,700
	X					X				-£5,400
		X				X				-£8,600
X			X			X				-£6,500
X	X					X				-£6,400
X		X				X				-£6,300
X	X					X			X	-£6,200
X			X		X					-£6,500
X			X	X						-£6,400
X			X			X	X			-£4,900
X	X					X	X			-£5,100
X		X				X	X			-£4,500
X	X					X	X		X	-£4,600
X			X			X	X	X		-£4,100
X	X					X	X	X		-£4,400
X		X				X	X	X		-£3,800
X			X			X		X		-£5,700
X	X					X		X		-£5,600
X		X				X		X		-£5,500
X	X					X	X	X	X	-£3,900

Notes: \*Wage restrictions: MI cut at £20,800 to avoid including pre-registration nurses. All coefficients are statistically significant at the 5 percent level. NHS nurses are those with "NHS" in the organisation name, private/care sector nurses include all nurses not NHS.  
Source: ASHE (2014) and Home Office Management Information, year ending March 2015.



## Abbreviations

ASHE	Annual Survey of Hours and Earnings
AfC	Agenda for Change
CfWI	Centre for Workforce Intelligence
CoS	Certificate of Sponsorship
CPI	Consumer Price Index
DEL	Departmental Expenditure Limit
DH	Department of Health
EEA	European Economic Area
EU	European Union
FTE	Full-time equivalent
HCAS	High Cost Area Supplements
HEE	Health Education England
HESA	Higher Education Statistics Agency
HMT	HM Treasury
HSC	Health Social Care
HSCIC	Health and Social Care Information Centre
IELTS	International English Language Testing System
IES	Institute for Employment Studies
IFS	Institute for Fiscal Studies
ISC	Immigration Skills Charge
ISD	Information Services Division Scotland
LFS	Labour Force Survey
MAC	Migration Advisory Committee
MFF	Market Forces Factor

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NAO	National Audit Office
NHS	National Health Service
NICE	National Institute of Health and Care Excellence
NMC	Nursing and Midwifery Council
NMDS-SC	National Minimum Data Set for Social Care
NQF	National Qualifications Framework
OECD	Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
OSCE	Objective Structured Clinical Exam
PBS	Points Based System
RCN	Royal College of Nursing
RCoS	Restricted Certificates of Sponsorship
RLMT	Resident Labour Market Test
RPI	Retail Price Index
RRP	Recruitment and Retention Premia
SCPHN	Specialist community public health nursing
SOC	Standard occupational code
SOL	Shortage occupation list
TDA	Trust Development Authority
UKCES	UK Commission for Employment and Skills
USD PPP	US Dollar purchasing power parity
WTE	Whole-time equivalent

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