HOUSE OF LORDS Library Briefing

Impact of Fiscal Policies on Recruitment, Retention and Conditions of NHS Staff Debate on 30 November 2017

Summary

This Lords Library Briefing has been prepared in advance of Lord Clark of Windermere's (Labour) debate scheduled to take place in the House of Lords on 30 November 2017, on the impact of Her Majesty's Government's fiscal policies on the recruitment, retention and conditions of NHS staff.

Data sourced from the NHS's payroll and human resources system provides information on the size of the workforce for NHS Hospital and Community Health Service staff groups. This shows a varied picture across different roles. Both the average annual headcount and FTE figures for nurses and health visitors have remained relatively constant since 2010, with the average number of FTEs rising from 282,237 in 2015 to 284,845 in 2016. The number of FTE General Practitioners, however, has decreased from 34,592 in September 2015 to 33,302 in September 2017. Concern has been expressed by some organisations that recruitment and retention of staff has been placed under pressure by the Government's public sector pay policy. The NHS Pay Review Body, which advises the Government on pay for Agenda for Change NHS staff (the national pay system for all NHS staff, with the exception of doctors, dentists and most senior managers), has said that the NHS is under significant affordability pressures with increased demand being accommodated within budgets that are "broadly flat in real terms". The Royal College of Nursing has said that in its most recent biennial employment survey 24 percent of respondents said that they were thinking of leaving their job because of money worries.

The Government has argued that the cap on pay increases within the NHS has enabled it to recruit 30,000 more staff since May 2010. However, in the Autumn 2017 Budget, the Chancellor of the Exchequer, Philip Hammond, announced that the Government would fund a new pay award following negotiations with health unions on modernising the pay structure for Agenda for Change staff. This was in order to improve recruitment and retention.

This briefing provides background information on NHS staffing in England. It provides summary statistics on UK government expenditure on health in the UK and a discussion of the public sector pay policy as regards the NHS. The briefing also provides selected commentary on the issue of pay in the NHS as it relates to recruitment. Finally, selected statistics on the NHS workforce in England are presented.

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Charley Coleman
24 November 2017

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1. Staffing in the NHS: Policy in England

In England, there is no legislative provision stipulating specific levels of staffing across all NHS services. The Government has stated that it has not sought a "prescriptive approach" to staffing levels because set minimum numbers for staffing or staffing ratios would not "take account of the local circumstances, skill mix or case mix".[1]

However, the Government has argued that appropriate staffing levels are a core factor considered by the Care Quality Commission (CQC) registration scheme.[2] This is underpinned by legislation, with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 providing for safety and quality requirements. The regulations set out the requirements which must be met for providers of regulated activities to be registered with CQC. These apply "to all providers of a regulated activity including NHS bodies (eg NHS Trusts, NHS Foundation Trusts, and Special Health Authorities), independent providers and voluntary sector organisations".[3] Section 2 of part 3 of the regulations sets out "fundamental standards", which includes a requirement for appropriate staffing:

> Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.[4]

In July 2016, the National Quality Board (NQB)[5] published a report providing a 'safe staffing improvement resource'. It built on previous guidance from 2013 and applied this to cover the broader multi-professional workforce in a range of care settings, as well as nursing and midwifery staffing.[6] The NQB stated that it could only "set the context" of appropriate staffing, and offer support to providers, because it was "local clinical teams—and local providers and commissioners—who will ensure we continue to provide high-quality and financially sustainable services".[7] The report sets the NQB's expectations of staffing decisions through a 'triangulated' approach covering three areas: 'Right Staff, Right Skills, Right Place and Time'.[8]

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[1] House of Commons, 'Written Question: NHS: Staff', 13 July 2017, 3547.
[2] ibid.
[3] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Explanatory Memorandum, para 2.1.
[4] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, paragraph 18.
[5] Which is comprised of: NHS Improvement, the Care Quality Commission, NHS England, National Institute for Health and Care Excellence, Health Education England, Public Health England, and the Department of Health.
[6] National Quality Board, *Supporting NHS Providers to Deliver the Right Staff, with the Right Skills, in the Right Place at the Right Time*, July 2016, p 7.
[7] ibid, p 4.
[8] ibid, pp 14–20.

Broadly these expectations cover the following areas:

Right Staff
1.1 evidence-based workforce planning
1.2 professional judgement
1.3 compare staffing with peers

Right Skills
2.1 mandatory training development and education
2.2 working as a multiprofessional team
2.3 recruitment and retention

Right Place and Time
3.1 productive working and eliminating waste
3.2 efficient deployment and flexibility
3.3 efficient employment and minimising agency[9]

These are used to then implement care hours per patient day and to develop local quality dashboards for safe sustainable staffing. The NQB argues that deciding staffing levels based on patient need, acuity and risks enables NHS provider boards to make appropriate judgements about delivering safe, sustainable and productive staffing.[10] The NQB says that this triangulated approach—as opposed to a system based solely on numbers or ratios of staff to patients—is supported by the CQC.[11]

NHS Improvement has established a series of national workstreams to develop safe staffing improvement resources for the following care settings: mental health; learning disability; community; maternity; acute inpatients; children's services; urgent and emergency care.[12]

2. UK Government Fiscal Policy

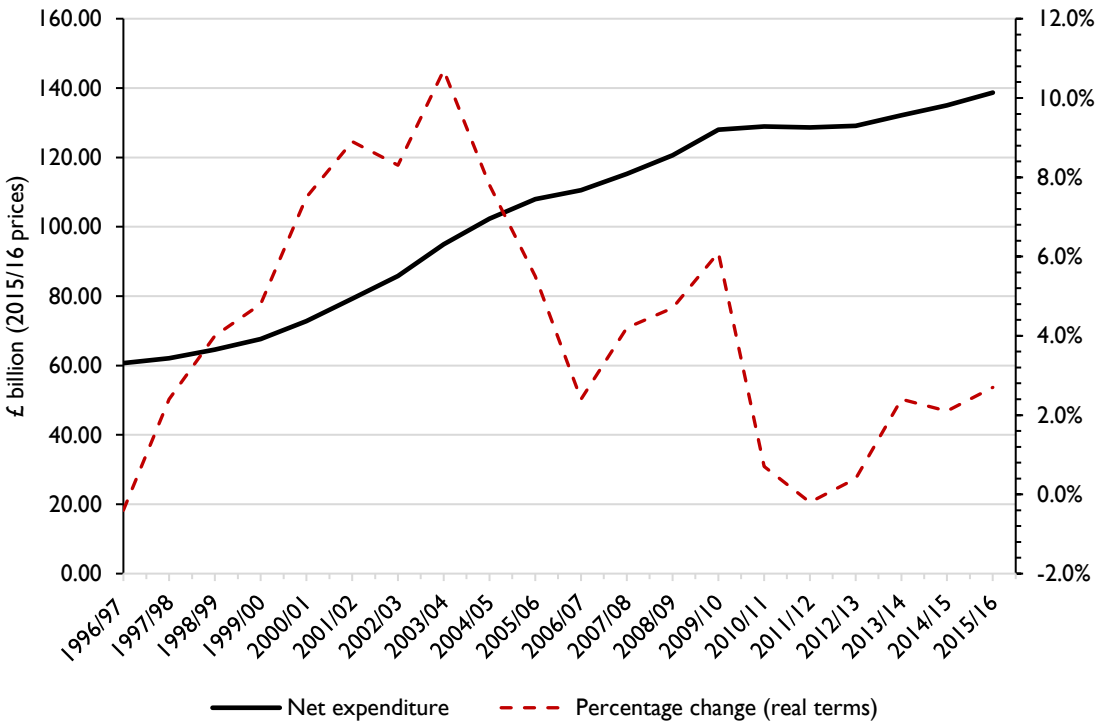
2.1 Expenditure on the NHS

Government net expenditure on health services has generally increased year on year since 1996/97, with the exception of 2010/11 to 2012/13.[13] The percentage change in the net expenditure of the Government on health has been variable, having a high of 10.7 percent in 2003/04 and a low of

[9] National Quality Board, *Supporting NHS Providers to Deliver the Right Staff, with the Right Skills, in the Right Place at the Right Time*, July 2016, p 14.
[10] ibid, p 4.
[11] ibid, p 4.
[12] NHS Improvement, 'Update on Safe Staffing Improvement Resources for Specific Care Settings', 6 July 2016.
[13] House of Commons Library, *NHS Expenditure*, 14 June 2017, table 1.

-0.4 percent in 1996/97. The low since 1996/97 was -0.2 percent in 2011/12. Since 2010/11, government net expenditure has on average increased by 1.4 percent each year between 2010/11 and 2015/16.

Chart 1: Net Government Expenditure on Health Services and Annual Percent Change, 1996/97 to 2015/16, UK



(Source: House of Commons Library, *NHS Expenditure*, 14 June 2017, table 1)

The Government has stated that the Hospital and Community Health Service's (HCHS) pay bill was £46.112 billion in 2015–16.[14] The HCHS workforce comprises of staff working within hospital and community health settings, and so excludes general practitioners (GPs), GP practice staff and General Dental Practitioners. NHS trusts and foundation trusts spend around 60 percent of their entire expenditure on pay.[15]

The Government's announcements on NHS funding and public sector pay (including on pay for Agenda for Change staff) in the Autumn 2017 Budget are outlined in section 4 of this briefing.

2.2 Public Sector Pay Policy and the NHS

Previously, the Government's public sector pay policy was set out in the Summer 2015 Budget and stated that it would fund pay awards of 1 percent

[14] House of Commons, 'Written Question: NHS: Pay', 19 July 2017, 4756.
[15] ibid.

until 2019–20:

> [T]he Government will […] fund public sector workforces for a pay award of 1 percent for 4 years from 2016–17 onwards. This will save approximately £5 billion by 2019–20.[16]

The Government also stated that it expected pay awards to be applied in a "targeted manner within workforces to support the delivery of public services".[17] Separate pay review bodies provide the Government with advice on pay awards within eight areas, including the NHS.[18] They make their recommendations taking into consideration the need to retain, recruit and motivate suitably qualified staff and the Government's public sector pay policy.[19]

The NHS Pay Review Body (NHSPRB) published its most recent report on pay in the NHS on 28 March 2017.[20] The NHSPRB's remit includes the 1.3 million people[21] on the NHS Agenda for Change pay system. Agenda for Change is the national pay system that covers all NHS staff, with the exception of doctors, dentists and most senior managers.[22] It recommended a 1 percent increase to all Agenda for Change pay points in England, Northern Ireland, Scotland and Wales.[23] However, the NHSPRB stated that in its judgement "we are approaching the point when the current pay policy will require some modification, and greater flexibility, within the NHS".[24] In March 2017, the Review Body on Doctors' and Dentists' Remuneration (RBDDR), the pay review body for doctors and dentists, similarly recommended a base increase of 1 percent to the national salary scales for salaried doctors and dentists in England, Northern Ireland, Scotland and Wales.[25]

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[16] HM Treasury, *Summer Budget 2015*, July 2015, HC 264 of session 2015–16, p 28.
[17] ibid.
[18] Office of Manpower Economics, 'Guidance: An Introduction to Pay Review Bodies', 6 August 2013.
[19] ibid. Further background on the Government's public sector pay policy is set out in: House of Commons Library, *Public Sector Pay*, 6 October 2017, pp 4–5.
[20] NHS Pay Review Body, *NHS Pay Review Body: Thirtieth Report 2017*, 28 March 2017, Cm 9440.
[21] ibid, p xi.
[22] NHS Employers, 'Agenda for Change', accessed 21 November 2017.
[23] NHS Pay Review Body, *NHS Pay Review Body: Thirtieth Report 2017*, 28 March 2017, Cm 9440, p xi. Scotland was considered in a supplemental report due to delays in submissions to the NHS Pay Review Body: *Thirtieth Report 2017 Scotland Supplement*, 28 March 2017, SG/2017/30.
[24] ibid.
[25] Review Body on Doctors' and Dentists' Remuneration, *Review Body on Doctors' and Dentists' Remuneration: Forty-Fifth Report 2017*, 28 March 2017, Cm 9441, p vii. Scotland was considered in a supplemental report due to delays in submissions to the Review Body on Doctors' and Dentists' Remuneration: *Forty-Fifth Report 2017 Scotland Supplement*, 28 March 2017, SG/2017/31.

In response to an oral question in the House of Commons on 10 October 2017, the Secretary of State for Health, Jeremy Hunt, stated that the Government recognised that it was "not sustainable to carry on with the 1 percent rise going forward, which is why we have been given the leeway to have more flexible negotiations next year".[26] Mr Hunt went on to say that "the pay cap has been scrapped".[27]

2.3 Withdrawal of Bursaries after August 2017

From 1 August 2017, new students on nursing, midwifery and most allied health pre-registration courses will no longer be able to receive bursaries.[28] Such students will now have to access the same student loans system as other students. Additional funding will be provided by the NHS Business Services Authority for those nursing, midwifery and allied health professional courses with a compulsory clinical placement.[29] The reforms were originally announced in the Autumn 2015 Budget. The Government consulted on the proposals between April and June 2016, and published its consultation response in July 2016.[30]

The Department of Health has said that the changes will help "secure the workforce" by:

- enabling universities to offer up to 10,000 extra training places on pre-registration healthcare programmes;
- offering students around 25 percent more upfront financial support while studying—for example, a single student on a 3-year programme would receive approximately £2,000 more each year on a student loan compared to an NHS bursary;
- improving access to pre-registration undergraduate study for those from disadvantaged backgrounds; and
- giving students with an existing qualification the chance to get funding for a second degree.[31]

The Health Foundation has stated applications for places in the autumn 2017 intake in nursing and allied health subjects had fallen by 23 percent (although this still exceeds the number of places available).[32] However, it argued that

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[26] HC *Hansard*, 10 October 2017, col 154.
[27] ibid.
[28] Department of Health, 'Policy Paper: NHS Bursary Reform', 27 January 2017.
[29] ibid.
[30] Further information can be found in: House of Commons Library, *Reform of Support for Healthcare Students in England*, 3 February 2017.
[31] Department of Health, 'Policy Paper: NHS Bursary Reform', 27 January 2017. Further information can be found in: House of Commons Library, *Reform of Support for Healthcare Students in England*, 3 February 2017.
[32] The Health Foundation, *Rising Pressure: The NHS Workforce Challenge: Workforce Profile and Trends of the NHS in England*, October 2017, p 4.

its analysis showed multiple factors behind this reduction:

> Applications to nursing are down across the UK, despite Northern Ireland, Scotland and Wales retaining the bursary system. The fall in England is sharper and is most notable among mature applicants. Until 2017, 40 percent of applicants to nurse education were aged 25 and over. The end of bursaries in England is one of several factors that may be affecting applications from this group: pay on graduation and wider opportunities in the labour market may also have an impact.[33]

As part of its '2017 application cycle' statistics releases, UCAS has been providing a separate analysis for applicants to nursing courses (UCAS, 'Undergraduate Applicant Releases for 2017 Cycle', accessed 24 November 2017).

3. Commentary on Staffing within the NHS

3.1 Recent Developments

In its March 2017 report, the NHSPRB stated that it did "not see significant short-term nationwide recruitment and retention issues that are linked to pay".[34] It said that whilst there were shortfalls of professional staff in some occupations (which included nursing and paramedics in some regions) the NHS workforce "increased in size in virtually every staff group in every country in the UK".[35] However, it did express concern that "home-grown" recruitment was insufficient to meet demand in some professional groups and that there was therefore a reliance on overseas nationals.[36]

Overall the NHSPRB argued it was "clear" that the current public sector pay policy was "coming under stress" and it reflected on what it called widespread concerns about recruitment, retention, and motivation. It also expressed concern about the impact of higher than predicted levels of inflation leading to real terms cuts in staff pay:

> Inflation is set to increase during 2017 compared to what was forecast leading to bigger cuts in real pay for staff than were anticipated in 2015, when current public sector pay policy was announced by the new UK Government. Local pay flexibilities to address recruitment and retention issues are not being used to alleviate the very shortages

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[33] The Health Foundation, *Rising Pressure: The NHS Workforce Challenge: Workforce Profile and Trends of the NHS in England*, October 2017, p 4.
[34] NHS Pay Review Body, *NHS Pay Review Body: Thirtieth Report 2017*, 28 March 2017, Cm 9440, p xiii.
[35] ibid.
[36] ibid.

> they were designed to address.[37]

The NHSPRB also argued the need for efficiencies could ultimately put pressure on recruitment. It was concerned that within the context of a slowly increased budget, alongside increased demand pressures, using pay to meet affordability risked impacting recruitment:

> We are concerned that holding down pay has become the default position for making efficiencies, as service transformation is not yet delivering. Reliance on pay to meet the affordability challenge risks putting further pressure on the real wages of NHS staff and creating a perception of unfairness, which could be counter-productive due to its impact on recruitment, retention and motivation.[38]

In its March 2017 report on doctors' and dentists' pay, the RBDDR wrote that problems remained with recruitment in some specialties, citing emergency medicine, psychiatry and general practice.[39] It described some of these issues as "stubborn" and said that non-pay solutions had been ineffective. Consequently, the RBDDR argued that pay-related options should be considered. As with the NHSPRB, the RBDDR expressed concern about the impact of inflation and wages on recruitment, retention and motivation:

> Wage growth across the economy generally at both the median and 90th percentile was well above 1 percent in 2016, which eroded the relative pay of doctors and dentists. Further to this, should inflation continue to increase as it is forecast to do, it will continue to lower real wages.[40]

During its inquiry, the House of Lords Long-term Sustainability of the NHS Committee examined the link between pay and morale. It said this was a particular problem for lower paid staff (including nurses) and that the duration of pay restraint in the NHS was going to have a negative effect on workforce morale:

> This was a particular problem for those who were often at the lower end of the pay scale such as nurses, other healthcare workers and social care workers. It was clearly a relevant factor in the low levels of morale and significant staff retention problems we heard about. Sam Higginson, Director of Strategic Finance at NHS England, told us that the working efficiency calculations within the Department of Health

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[37] NHS Pay Review Body, *NHS Pay Review Body: Thirtieth Report 2017*, 28 March 2017, Cm 9440, p xii.
[38] ibid.
[39] Review Body on Doctors' and Dentists' Remuneration, *Review Body on Doctors' and Dentists' Remuneration: Forty-Fifth Report 2017*, 28 March 2017, Cm 9441, p x.
[40] ibid.

> assumed that pay restraint would continue up to 2019/20. Michael Macdonnell, Director of Strategy at NHS England, conceded that in his opinion, 10 years of prolonged pay restraint were bound to have long-term effects on workforce morale.[41]

The Committee referenced the House of Commons Public Accounts Committee which in its May 2016 report *Managing the Supply of NHS Clinical Staff in England* stated that:

> The limited available data suggest that, within NHS hospital and community healthcare services, the proportion of nurses leaving increased from 6.8 percent in 2010–11 to 9.2 percent in 2014–15.[42]

The House of Lords Committee recommended that the Government commission a formal independent review into pay policy with a particular regard to its impact on the morale and retention of health and care staff.[43] At the time of writing the Government had not yet responded to the Committee's report.

On 30 October 2017, the Institute for Public Policy Research (IPPR) published an analysis of the impact of lifting the pay cap for NHS staff.[44] The IPPR argued that a 'band 5' nurse in England was paid 10.1 percent less in real terms in 2017/18 then they were in 2010/11.[45] It cited real terms pay declines as a contributory factor in "increasing challenges" in recruiting and retaining staff within the NHS. The IPPR argued that this had led to a reliance on agency nurses who were more expensive than directly employed staff:

> The agency bill as a proportion of total pay in the NHS in England nearly doubled between 2011/12 and 2015/16, reaching £3.6 billion in that year, with a bill of around £250 million in the other nations of the UK. The cost of agency staff is far higher than the equivalent cost of directly employed staff, leaving the NHS facing an 'agency premium' of hundreds of millions of pounds as a result of not being able to secure sufficient permanent staff.[46]

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[41] House of Lords Long-term Sustainability of the NHS Committee, *The Long-term Sustainability of the NHS and Adult Social Care*, 5 April 2017, HL Paper 151 of session 2016–17, p 42.
[42] House of Commons Public Accounts Committee, *Managing the Supply of NHS Clinical Staff in England*, 11 May 2016, HC 731 of session 2015–16, p 5.
[43] House of Lords Long-term Sustainability of the NHS Committee, *The Long-term Sustainability of the NHS and Adult Social Care*, 5 April 2017, HL Paper 151 of session 2016–17, p 43.
[44] Institute for Public Policy Research, *The Fiscal and Economic Impact of Lifting the NHS Pay Cap*, October 2017.
[45] ibid, p 5.
[46] ibid, p 3.

The IPPR examined three different scenarios of increased pay arguing that any increase was lower than the 'headline' cost if receipts returned to the Treasury and reduced welfare payments were considered:

> If pay in the NHS were to be uprated in line with CPI between now and 2019/20, rather than in line with the Government's cap, then the additional annual cost of the pay bill for the whole of the UK would be £1.8 billion in 2019/20. However, when taking into account the fiscal impact of money immediately returned to the Treasury through higher tax receipts and lower welfare payments, the net cost falls to £1.1 billion. While the headline cost of our catch-up scenario would be £3.9 billion a year by 2019/20, the net cost would be far lower at £2.3 billion.[47]

The IPPR stated that despite the lower headline costs any lifting of the pay cap would need to be funded by the Government to avoid "escalat[ing] the financial crisis in the NHS" and coming at the cost of patient care.[48] The IPPR recommended that the pay cap be lifted and extra funding be provided to cover this.

The Royal College of Nursing (RCN) welcomed the IPPR's report. The RCN's Chief Executive, Janet Davies, stated that:

> The Chancellor should allocate appropriate funding to cover a pay award at the level of inflation—anything less amounts to another pay cut. With unprecedented deficits in the NHS, he cannot ask it to cover pay rises from within existing spending. The NHS must be given new funding to cover the cost.[49]

The RCN has argued its most recent biennial employment survey has shown that pay factors into its members' career decisions and has potential consequences for recruitment and retention. Of its members who responded:

- 70 percent reported feeling financially worse off than they were five years ago;
- 24 percent say they are thinking of leaving their job because of money worries;
- the percentage of respondents who say they are looking for a new job has also increased from 24 percent ten years ago to 37 percent today; and

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[47] Institute for Public Policy Research, *The Fiscal and Economic Impact of Lifting the NHS Pay Cap*, October 2017, p 3.
[48] ibid, p 4.
[49] Royal College of Nursing, 'Half the Cost of Lifting the NHS Pay Cap Would Come Back to the Government, According to Think Tank', 30 October 2017.

- 61 percent say their job band or grade is inappropriate for the work they do, a significant increase on the last survey in 2015, when only 39 percent said this was the case.[50]

The RCN said its members were less likely to recommend a career in nursing:

> As a result of these severe financial and workload pressures, nursing staff are now less likely than at any point in the previous ten years to say they would recommend nursing as a career to others—only 41 percent said they would do so this year, compared with 51 percent in 2007.[51]

On 22 September, the British Medical Association (BMA) published an analysis of data on doctor training obtained by freedom of information requests.[52] The BMA found that applications to UK medical schools had decreased by more than 13 percent since 2013. Applications had fallen for the third year in a row. The BMA also stated that there was "significant" geographical variations in vacancy rates with the North East, North West and Yorkshire and the Humber experiencing the lowest fill rates.[53] The BMA stated that fill rates were higher in London and southern regions. It also expressed concern that in several areas of medical specialty, recruitment rates for trainees could cause issues with service delivery in the future:

> Workforce shortages in areas such as general practice and emergency medicine are well known, however these figures show that dozens of other specialties are also unable to recruit enough trainees, calling into question the NHS's ability to deliver specialist services in the same way in the future.[54]

The BMA argued that one factor behind its figures was the cost of qualification, stating that "for many student debt can exceed £80,000 (including maintenance)" and that medical graduates on an "average salary are unlikely to repay their Student Loans Company debt in full".[55] The BMA also cited "rising workloads, worsening morale [and] the NHS pay cap".[56]

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[50] Royal College of Nursing, 'Nursing Staff Stretched to Breaking Point Over Pay', 15 November 2017.
[51] ibid.
[52] British Medical Association, 'Staffing Crisis in NHS Laid Bare, as New BMA Analysis Shows that Three Quarters of Medical Specialties Face Shortage of Doctors', 22 September 2017.
[53] ibid.
[54] ibid.
[55] ibid.
[56] ibid.

Speaking to an NHS Providers conference on 8 November 2017, the Chief Executive of NHS England, Simon Stevens, said that an extra £4 billion was needed next year for the NHS.[57] The *Telegraph* reported that Mr Stevens said that this would only represent a return to the average rises seen in the six decades before 2010 and that an increase of 0.4 percent next year would mean "deeper rationing of care, staff cuts and record waiting lists".[58]

The Government has stated that staffing in the health service is a priority and that it had invested in the "frontline":

> There are around 11,800 more full time equivalent hospital and community doctors since May 2010, and 13,300 more full time equivalent nurses than in May 2010. With almost 52,000 doctors and 51,000 nurses in training, we will continue to make sure we have the staff available to give patients high quality care 24 hours a day, seven days a week.[59]

The Secretary of State for Health, Jeremy Hunt, has argued that the NHS would not have been able to afford to recruit "an additional 30,000 staff since May 2010 without the cap".[60]

3.2 Vacancies in NHS England

Data on vacancies within the NHS are published by NHS Digital, drawn from the administrative system used to advertise such positions. However, it should be noted that NHS Digital states that this data should be "used with caution" and the statistics are "exploratory and provide information on the administrative data available from NHS Jobs as much as on the recruitment of staff".[61] There are consequences of the data being drawn from this source:

- Only data on NHS Trusts, CCGs, Support Organisations and Central bodies in England are included. The figures do not include vacancy data for GPs or practice staff. Staff recruited into the NHS using other mechanisms, such as other recruitment websites or recruitment agencies are also excluded.[62]
- One job advert may be used to fill multiple vacancies and some may function on a rolling basis. NHS Digital therefore argue that

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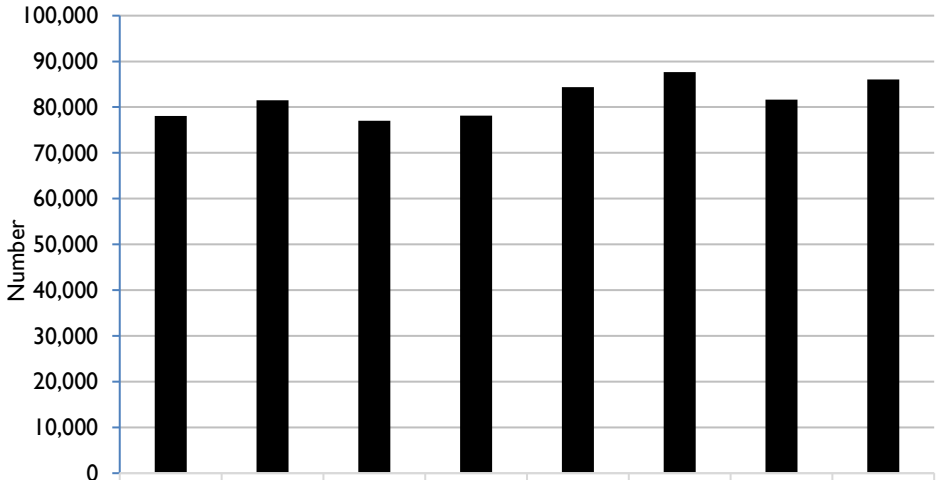
[57] Laura Donnelly, 'Record 5m Patients Will be Left on NHS Waiting Lists Without Brexit Cash Boost, Health Chief Warns', *Telegraph* (£), 8 November 2017.
[58] ibid.
[59] House of Commons, 'Written Question: NHS: Staff', 7 February 2017, 908637.
[60] HC *Hansard*, 10 October 2017, col 154.
[61] NHS Digital, 'NHS Vacancy Statistics England, February 2015 to March 2017, Provisional Experimental Statistics', 25 July 2017.
[62] NHS Digital, *NHS Vacancy Statistics England, February 2015 to March 2017, Provisional Experimental Statistics*, 25 July 2017, p 4.

> the data should be seen as the "minimum number of vacancies advertised".[63]

The most recent release of this data was published on 25 July 2017. Chart 2 shows data for the total number of advertised vacancy FTEs.

Chart 2: Total Number of Advertised Vacancy FTEs Published Within Each Quarter, Q1 2015 to Q4 2016, England



	Q1 2015	Q2 2015	Q3 2015	Q 4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Total Number of Adverts	78,051	81,516	77,047	78,112	84,384	87,666	81,674	86,035

(Source: NHS Digital, 'NHS Vacancy Statistics England, February 2015 to March 2017: Provisional Experimental Statistics', 25 July 2017, Table 2a)

In Q4 2016, 32,929 (or 38 percent) of these were for the 'nursing and midwifery registered' staff group and 11,155 (or 13 percent) were for 'medical and dental'. The registered nursing and midwifery group was the single largest group of vacancies in Q4 2016 and had been in all quarters in the data series (since Q1 2015).

In reporting the data, BBC News quoted Mark Holland, Council Member for the Society of Acute Medicine, as saying that:

> This data shows it is high time we saw steps taken to stop disincentivizing staff—salaries must be fair, working conditions must be safe and sustainable and clear career pathways must be in place.[64]

The BBC also said that the Department of Health had said that the seasonal way in which staff are recruited (with more joining the NHS between late

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[63] NHS Digital, *NHS Vacancy Statistics England, February 2015 to March 2017, Provisional Experimental Statistics*, 25 July 2017, p 4.
[64] BBC News, 'More Than 86,000 NHS Posts Vacant, Says Report', 25 July 2017.

summer and mid-winter) could account for some of the trends in the report.[65]

Writing in 2016 and citing data from 2014, the National Audit Office (NAO) wrote that there was an overall staffing shortfall of approximately 5.9 percent.[66] The NAO stated that this equated to a gap of around 50,000 clinical staff, with shortfalls varying between different staff groups and regions.

The Nuffield Trust has argued that financial problems can be solved by increased funding, whereas "it is far more difficult to solve workforce ones: when medical and other clinical professionals leave, they are not easily or quickly replaced".[67]

Reporting on a speech by Ian Cumming, Chief Executive of Health Education England (HEE), at its 2017 conference, the NHS Confederation wrote that "between 2016 and 2018, 87,000 nurses will leave, not retire from, the NHS. And though 84,000 will come back, only 64,000 newly qualified nurses will start in that period".[68] It reported that insufficient flexibility in working patterns was the main reason for nurses leaving the NHS, according to HEE statistics.[69]

In December 2016, the BMA published the results of survey of 3,567 GP partners which it had conducted (GP partners are the GPs who oversee and run GP practices in England).[70] The survey found that:

- almost a third of GP partners (31 percent) have been unable to fill vacancies in the last twelve months. A further one in five (18 percent) stated it takes between three and six months to recruit to a vacancy;
- the West Midlands (35 percent), the East of England (35 percent) and the East Midlands (34 percent) were the areas with the highest levels of vacancies that were not filled within twelve months or longer;
- only one in eight GP partners (13 percent) reported not needing to fill a gap in their workforce;

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[65] BBC News, 'More Than 86,000 NHS Posts Vacant, Says Report', 25 July 2017.
[66] National Audit Office, *Managing the Supply of NHS Clinical Staff in England*, 5 February 2016, HC 736 of session 2015–16, p 6.
[67] Nuffield Trust, 'The NHS Workforce in Numbers', 30 October 2017, accessed 23 November 2017.
[68] NHS Confederation, 'Look After Current Staff to Secure the Future NHS Workforce, Says Ian Cumming', 15 June 2017.
[69] ibid.
[70] British Medical Association, 'A Third of GP Partners Unable to Fill Staff Vacancies for 12 Months, Warns New BMA Survey', 5 December 2016.

- around a third of GP partners who need to hire locums do so in order to cover long term employment vacancies (31 percent) or to be able to continue to provide a full range of services (30 percent) to their patients; and
- there was a strong relationship between GPs' workload and the ability of their practice to fill vacancies. Over four in ten GP partners (44 percent) who described their workload as excessive and significantly impacting on care also report being unable to fill vacancies, compared to only around one in seven (14 percent) of this group who say their practice has been able to fill vacancies within a reasonable timeframe.[71]

4. Autumn 2017 Budget

In its 2017 general election manifesto the Conservative Party stated it would increase NHS spending by a minimum of £8 billion in real terms over the next five years. This would yield an "increase in real funding per head of the population for every year of the parliament".[72]

At the Autumn 2017 Budget the Government announced £6.3 billion of additional funding for the NHS. This would consist of £3.5 billion in capital by 2022–23 and an additional £2.8 billion of resource funding. HM Treasury described this as a "significant step towards meeting the Government's commitment to increase NHS spending by a minimum of £8 billion in real terms by the end of this parliament".[73]

On the subject of wider public sector pay, the Government stated that it intended to move away from the 1 percent basic public sector pay award policy. For those roles covered by a Pay Review Body (PRB), the relevant Secretary of State would write to the PRB chair to start the 2018–19 pay round. Later they would submit evidence on recruitment and retention data. The PRB would then make recommendations based on this evidence in the spring or summer. The Secretary of State would then make pay decisions passed on the PRB's recommendations, taking into account "their affordability".[74]

In relation to pay within the NHS, the Government announced that in order to "protect frontline services" in the NHS it was committed to fund pay awards as part of a new pay deal for NHS staff on Agenda for Change contracts. However, any such deal would be linked to improved productivity in the NHS, and is "justified on recruitment and retention grounds".[75] The

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[71] British Medical Association, 'A Third of GP Partners Unable to Fill Staff Vacancies for 12 Months, Warns New BMA Survey', 5 December 2016.
[72] Conservative Party, *The Conservative Party Manifesto 2017*, 18 May 2017, p 66.
[73] HM Treasury, *Autumn Budget 2017*, November 2017, HC 587 of session 2017–19, p 3.
[74] ibid, p 68.
[75] ibid, p 66.

role of NHSPRB in recommending the pay levels would not change.

During his Autumn 2017 Budget Statement, the Chancellor of the Exchequer, Philip Hammond, said that the Secretary of State for Health was in discussion with health unions about modernising the pay structure for Agenda for Change staff in order to improve recruitment and retention.[76] The Chancellor stated that if these discussions resulted in increased pay he would provide additional funding to protect patient services:

> I want to assure NHS staff and patients, that if the Health Secretary's talks bear fruit, I will protect patient services by providing additional funding for such a settlement.[77]

Referring to Agenda for Change staff, in its response to the Budget the Chief Executive of the Nuffield Trust, Nigel Edwards, stated that the Chancellor had "committed" to funding a pay settlement for nurses, midwives and some other NHS staff but "there appears to be no commitment to funding pay increases for medical staff".[78]

4.1 Responses to the Autumn 2017 Budget

Responding to the Budget, the Leader of the Opposition, Jeremy Corbyn, questioned where the money to fund the NHS pay rise would come from and accused the Chancellor of having "not been clear".[79] He argued that the additional money the Chancellor announced for the NHS was "well short of what is needed" for the NHS's budget in general.[80]

Expressing his personal view on the Budget, Professor Sir Bruce Keogh, NHS England's National Medical Director, tweeted that the Budget:

> [P]lugs some, but def[initely] not all, of NHS funding gap. Will force a debate about what the public can and can't expect from the NHS. Worrying that longer waits seem likely/unavoidable.[81]

This was a view echoed by Professor Sir Malcom Grant, Chair of NHS England, who was quoted by the *Guardian* as arguing that the extra money "will go some way towards filling the widely accepted funding gap [but] We can no longer avoid the difficult debate about what it is possible to deliver

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[76] HC *Hansard*, 22 November 2017, col 1054.
[77] ibid.
[78] Nuffield Trust, 'Nuffield Trust Response to the Autumn Budget 2017', 22 November 2017.
[79] HC *Hansard*, 22 November 2017, col 1063.
[80] ibid.
[81] Professor Sir Bruce Keogh, Personal Twitter Account, 22 November 2017.

for patients with the money available".[82]

Similarly, NHS Providers stated that the new funding in the Budget was "less than the NHS needed but more than was expected".[83] However, consequently, "tough choices are now needed and trade-offs will have to be made […] it is difficult to see how the NHS can deliver everything in 2018/19".[84]

The RCN has said that the Budget recognised the efforts of its members in campaigning for pay increases. The RCN's Chief Executive, Janet Davies, welcomed the announcement on NHS pay but said such a rise would have to be "meaningful".[85] She also expressed concern that this would come at the expense of nurses working "even harder":

> The NHS has been running on the goodwill of its staff for too long, and with more talk of reform and productivity, Hammond runs the risk of insulting nurses who regularly stay at work unpaid after 12-hour shifts. Their goodwill will not last indefinitely.[86]

The RCN has said that it is calling for a pay rise in line with the retail price index plus £800 to begin to make up for "the years of lost pay". It would now submit evidence to the NHSPRB, referencing its staff survey.[87]

In its response, the British Medical Association's council chair, Dr Chaand Nagpaul, said the additional funding "may ease some short-term pressures" but that it was not sufficient to meet long-term funding problems.[88] He also argued that providing "fair terms and conditions" should be an urgent priority, referencing BMA-obtained data[89] which showed that "nearly three quarters of all medical specialties had unfilled training posts in 2016".[90] Dr Nagpaul described recruitment and retention as a key challenge for the

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[82] Denis Campbell, 'Budget's £1.6bn Cash Boost for NHS Less Than Half of Experts' Advice', *Guardian*, 22 November 2017.
[83] NHS Providers, 'Less Than Needed: More Than Expected: NHS Providers Response to the Budget', 22 November 2017. NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services.
[84] NHS Providers, 'Less Than Needed: More Than Expected: NHS Providers Response to the Budget', 22 November 2017.
[85] Royal College of Nursing, 'Fair Pay for NHS Nursing Staff Moves a Step Closer', 22 November 2017.
[86] ibid.
[87] ibid.
[88] British Medical Association, 'Chancellor's Budget Was a Missed Opportunity to Provide Vital Support for NHS', 22 November 2017.
[89] British Medical Association, 'Staffing Crisis in NHS Laid Bare, as New BMA Analysis Shows that Three Quarters of Medical Specialties Face Shortage of Doctors', 22 September 2017.
[90] British Medical Association, 'Chancellor's Budget Was a Missed Opportunity to Provide Vital Support for NHS', 22 November 2017.

NHS, with "workloads rising and doctors' pay having fallen by 22 percent over the last decade".[91] He argued that the Budget "has offered no solution to this crisis".[92]

Professor Helen Stokes-Lampard, chair of the Royal College of GPs (RCGPs), stated that whilst she welcomed the additional funding for the NHS it was disappointing that the Chancellor "has overlooked the increased pressures that GPs and our teams will be under, and the role general practice plays in alleviating pressures on our colleagues in secondary care".[93] She added that whilst the RCGPs "did not begrudge our hospital colleagues more investment" the "vast majority" of patient contact with the NHS came through contacts with general practice and it deserved "our fair share of any funding to help us cope this winter as well". She also said the funding announced was less than Simon Stevens, Chief Executive of NHS England, had requested:

> The £2.8 billion announced for the NHS today falls well short of Stevens' plea for £4 billion over the next three years—in fact it's less than £1 billion a year—and while any increased spending on the NHS is welcome, this is clearly not enough.[94]

The Institute for Fiscal Studies' Director, Paul Johnson, described the Chancellor's increased health spending as "modest in the context of easily the tightest decade for the NHS since its founding".[95] The IFS' Deputy Director, Carl Emmerson, argued that the £1.6 billion extra allocated for 2019–20 should be viewed in the "context of an NHS budget of about £125 billion".[96] He also stated that the NHS is facing pressure not just because of an increased population but also because the average age is also increasing:

> So if we adjust the NHS budget not just for the number of people in the country but also for the age of those people, we can see that the increases in NHS spending look far less generous and in fact per capita age adjusted spending on the NHS is pretty much flat and will be pretty flat even if the Conservative manifesto commitment is delivered.[97]

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[91] ibid. Dr Nagpaul referenced a report by University College London and the National Institute of Economic and Social Research, which was commissioned by the Office of Manpower Economics, *Wage Growth in Pay Review Body Occupations*, June 2017.
[92] ibid.
[93] Royal College of GPs, 'GPs Miss Out On Funding For Winter Pressures in Disappointing Budget for General Practice, Says RCGP', 22 November 2017.
[94] ibid.
[95] Institute for Fiscal Studies, 'Autumn Budget Analysis 2017: Opening Remarks and Summary', 23 November 2017.
[96] Institute for Fiscal Studies, 'Video: Autumn Budget 2017: Public Spending: Delaying the Squeeze', 23 November 2017.
[97] ibid.

The King's Fund's Director of Policy, Richard Murray, described the increased money for the NHS as "a welcome shot in the arm as the services struggles to meet rising demand for services".[98] However, Mr Murray stated that this was "still significantly less than the £4 billion we estimate the NHS needs next year".[99]

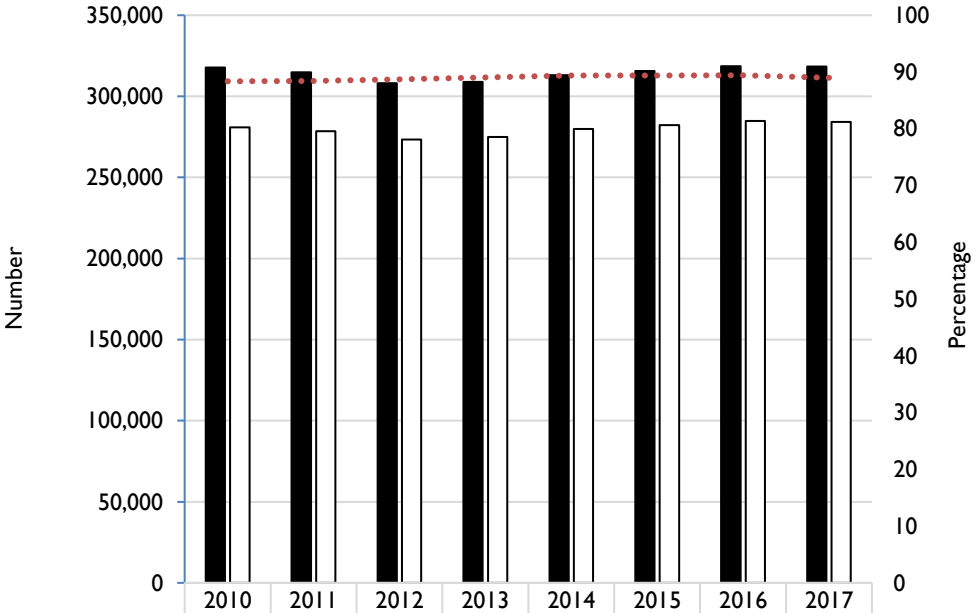
[98] King's Fund, 'The King's Fund Responds to the 2017 Autumn Budget', 22 November 2017.
[99] ibid.

5. Selected Statistics on the NHS Workforce

5.1 NHS Hospital and Community Health Service Staff

NHS Digital publishes monthly data on workforce headcount and full time equivalent (FTE) staff numbers in NHS Hospital and Community Health Service (HCHS) staff groups working in Trusts and CCGs in England (excluding primary care staff such as GPs).[100] The data is originally sourced from the NHS payroll and human resources system, 'ESR'.[101] Charts 3 to 8 display selected data taken from the data tables accompanying the NHS Workforce Statistics.

Chart 3: Nurses and Health Visitors, Headcount and FTE, Yearly Average Full Time Equivalent, 2010 to 2017, England



	2010	2011	2012	2013	2014	2015	2016	2017
Headcount	317,811	314,786	308,202	308,819	313,060	315,657	318,548	318,306
Full-time Equivalent	280,836	278,411	273,368	274,953	279,855	282,237	284,845	284,269
Percentage FTE to HC	88	88	89	89	89	89	89	89

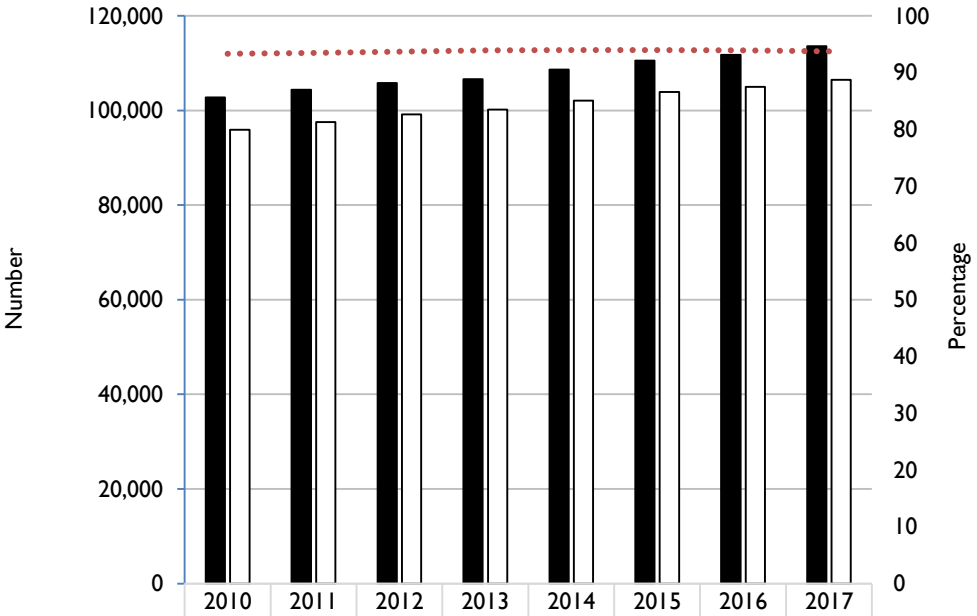
(Source: NHS Digital, 'NHS Workforce Statistics: July 2017, Provisional Statistics', 24 October 2017, yearly average calculated from monthly data by Lords Library, 2017 data is January to 31 July)

[100] NHS Digital, 'NHS Workforce Statistics: July 2017, Provisional Statistics', 24 October 2017.

[101] "This data is an accurate summary of the validated data extracted from the NHS's HR and Payroll system. It has a provisional status as the data may change slightly over time where trusts make updates to their live operational systems" (NHS Digital, *NHS Workforce: Statistics July 2017 Provisional Statistics*, 24 October 2017). Note that headcount refers to the total number of staff in either part time or full time employment within an organisation and/or area of work. Subtotals such as Health Education England (HEE) totals or areas of work totals are unlikely to add up to match the national figures because at a national level figures would only include a count of each individual once. However it is possible for that individual to be working in two part time roles in more than one HEE and/or area of work. In these cases they would appear once in each HEE and/or area of work (ibid, p 10).

Both the average annual headcount and FTE figures for nurses and health visitors have remained relatively constant since 2010. The average number of FTEs was lowest in 2012 (273,368) and highest in 2016 (284,845).

Chart 4: HCHS Doctors in Trusts and CCGs, Headcount and FTE, Yearly Average Full Time Equivalent, 2010 to 2017, England

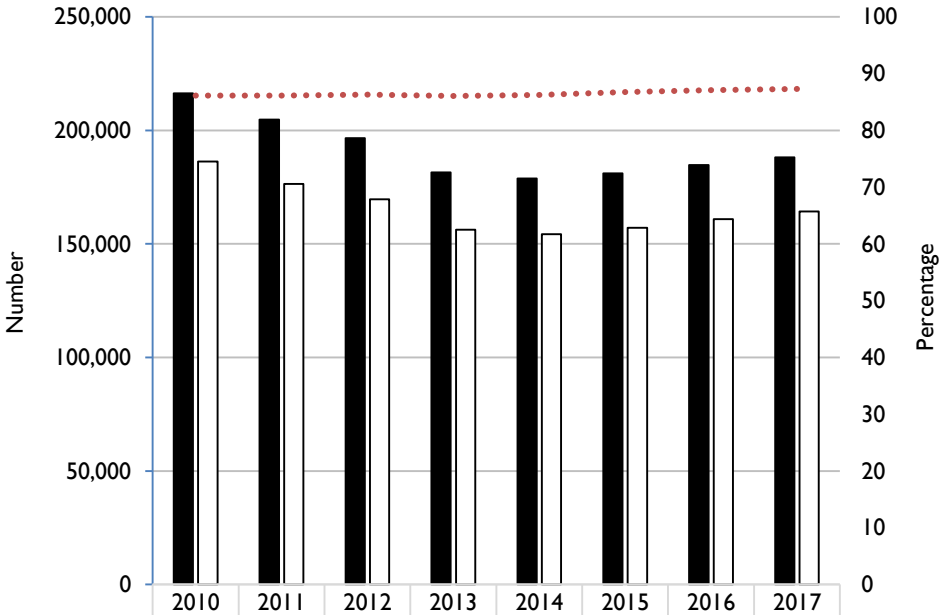


	2010	2011	2012	2013	2014	2015	2016	2017
Headcount	102,780	104,362	105,813	106,639	108,683	110,541	111,750	113,608
Full-time Equivalent	95,930	97,556	99,166	100,178	102,125	103,889	104,988	106,510
Percentage FTE to HC	93	93	94	94	94	94	94	94

(Source: NHS Digital, 'NHS Workforce Statistics: July 2017, Provisional Statistics', 24 October 2017, yearly average calculated from monthly data by Lords Library, 2017 data is January to 31 July)

The headcount and FTE figures for HCHS doctors have shown a consistent increase since 2010, with the number of FTEs increasing from 95,930 to 106,510, an increase of 10,580.

Chart 5: NHS Infrastructure Support Staff in Trusts and CCGs, Headcount and FTE, Yearly Average Full Time Equivalent, 2010 to 2017, England

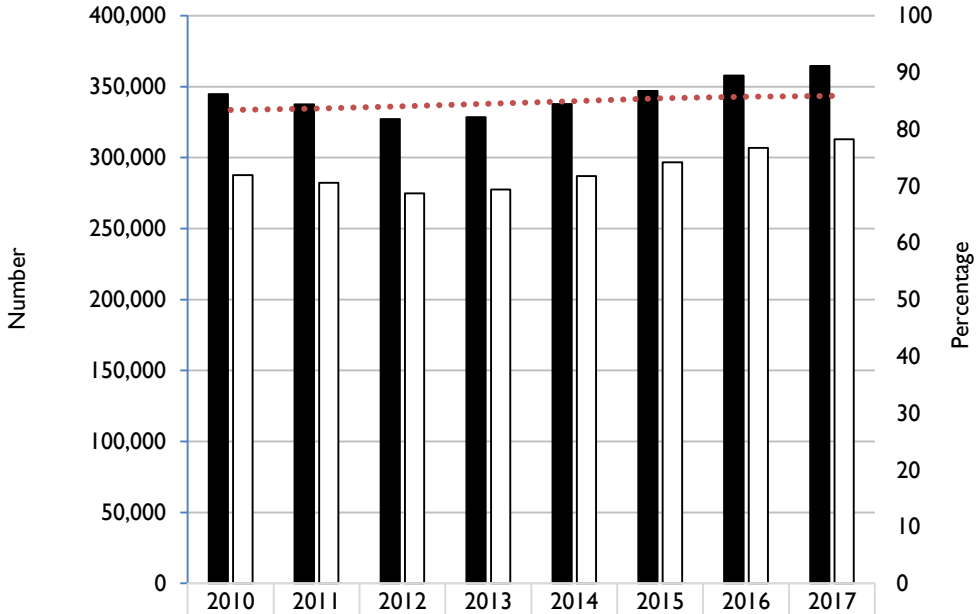


	2010	2011	2012	2013	2014	2015	2016	2017
Headcount	216,301	204,784	196,582	181,485	178,834	181,097	184,674	188,191
Full-time Equivalent	186,263	176,385	169,655	156,197	154,246	157,113	160,880	164,304
Percentage FTE to HC	86	86	86	86	86	87	87	87

(Source: NHS Digital, 'NHS Workforce Statistics: July 2017, Provisional Statistics', 24 October 2017, yearly average calculated from monthly data by Lords Library, 2017 data is January to 31 July. Roles included: 'central functions'; 'hotel, property and estates'; 'senior managers'; and 'managers'.)

The headcount and FTE figures for NHS infrastructure support staff saw a decrease between 2010 and 2014, with FTEs falling from 186,263 to 154,246. Since 2014 numbers of FTEs have increased to an average of 160,880 in 2016. This is 25,383 fewer than the average number in 2010.

Chart 6: Support to Clinical Staff in Trusts and CCGs, Headcount and FTE, Yearly Average Full Time Equivalent, 2010 to 2017, England

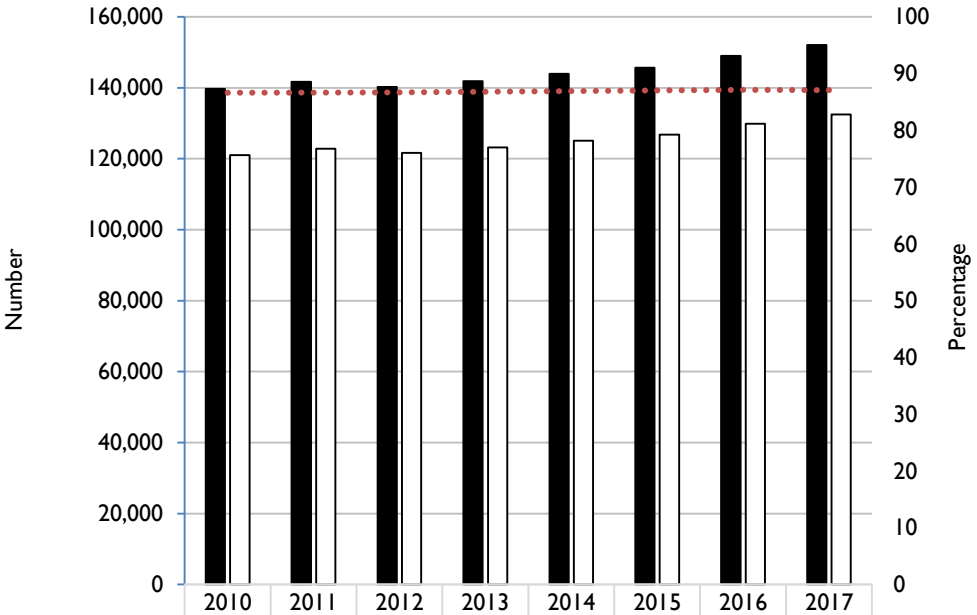


	2010	2011	2012	2013	2014	2015	2016	2017
Headcount	344,865	337,530	327,120	328,526	337,809	347,120	357,922	364,523
Full-time Equivalent	287,629	282,292	274,928	277,607	286,988	296,612	306,834	313,034
Percentage FTE to HC	83	84	84	85	85	85	86	86

(Source: NHS Digital, 'NHS Workforce Statistics: July 2017, Provisional Statistics', 24 October 2017, yearly average calculated from monthly data by Lords Library, 2017 data is January to 31 July)

The headcount and FTE figures for 'support to clinical staff' roles saw a decrease between 2010 and 2012, falling from an average of 287,629 FTEs in 2010 to an average of 274,928 in 2012. Since then the average number of FTEs has increased to 306,834 in 2016. Support to clinical staff includes support to doctors, nurses and midwives, ambulance staff and to scientific, therapeutic and technical staff. This includes a range of roles including healthcare workers and healthcare science assistants.

Chart 7: Scientific, Therapeutic and Technical Staff in Trusts and CCGs, Headcount and FTE, Yearly Average Full Time Equivalent, 2010 to 2017, England

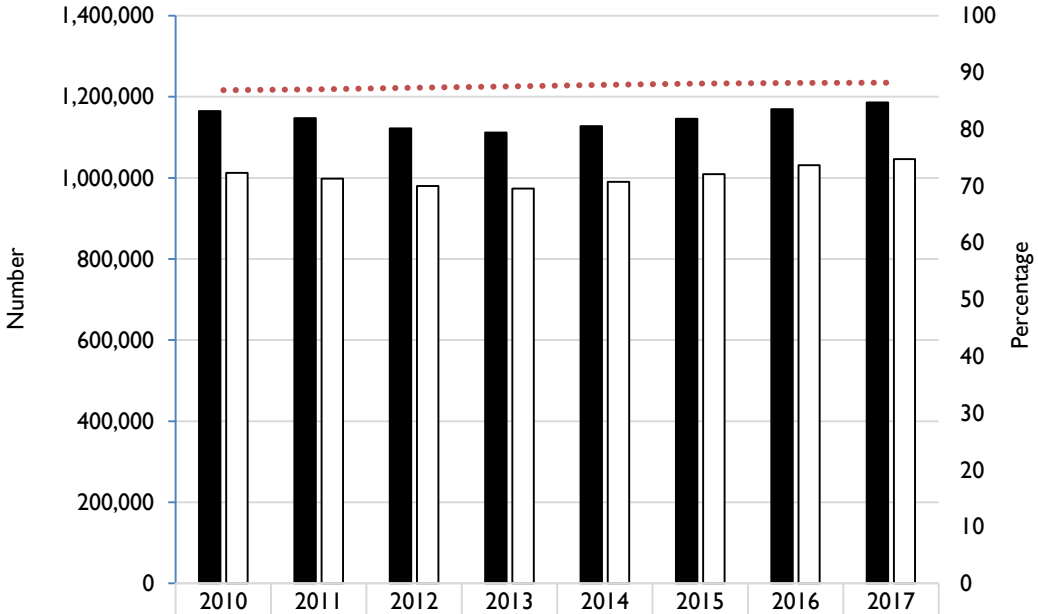


	2010	2011	2012	2013	2014	2015	2016	2017
Headcount	139,671	141,729	140,287	141,847	143,915	145,685	149,006	152,098
Full-time Equivalent	121,037	122,815	121,643	123,158	125,116	126,804	129,841	132,475
Percentage FTE to HC	87	87	87	87	87	87	87	87

(Source: NHS Digital, '[NHS Workforce Statistics: July 2017, Provisional Statistics]', 24 October 2017, yearly averaged calculated from monthly data by Lords Library, 2017 data is January to 31 July)

The average annual headcount and FTE figures for scientific, therapeutic and technical staff remained relatively constant between 2010 and 2013 (at an average of 122,163 FTE), but since 2013 average FTEs increased to 129,841 in 2016.

Chart 8: Total Staff in Trusts and CCGs, Headcount and FTE, Yearly Average Full Time Equivalent, 2010 to 2017, England



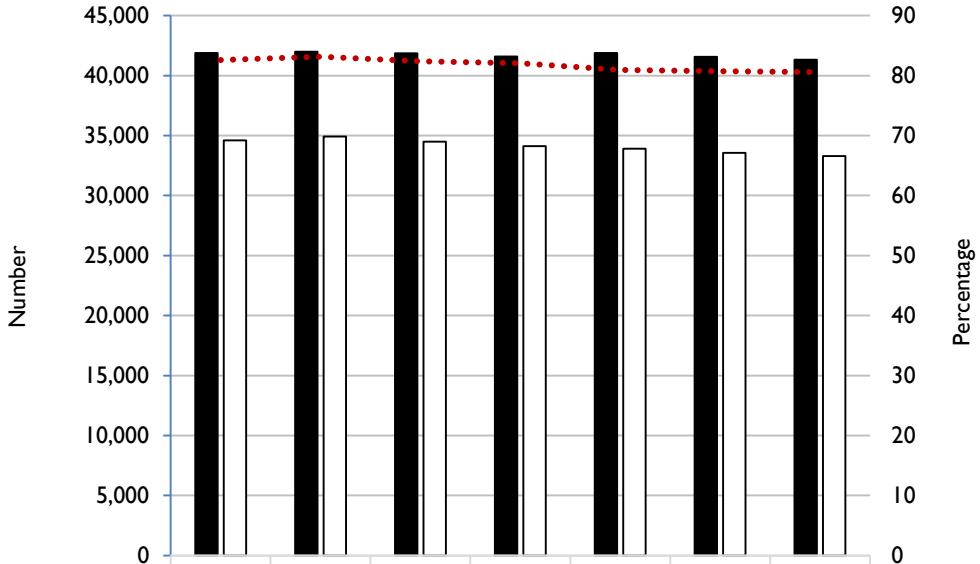
	2010	2011	2012	2013	2014	2015	2016	2017
Headcount	1,164,998	1,147,347	1,122,556	1,112,227	1,127,780	1,146,278	1,169,905	1,186,200
Full-time Equivalent	1,012,251	998,486	980,092	973,763	990,435	1,009,354	1,031,718	1,046,265
Percentage FTE to HC	87	87	87	88	88	88	88	88

(Source: NHS Digital, 'NHS Workforce Statistics: July 2017, Provisional Statistics', 24 October 2017, yearly averaged calculated from monthly data by Lords Library, 2017 data is January to 31 July)

Data for all staff included in the NHS Workforce Statistics release show that headcount and FTE have, overall, remained relatively consistent between 2010 and 2016. A low of an average 973,763 FTEs was reached in 2013 with a high of 1,031,718 in 2016, a difference of 57,955.

5.2 General Practitioners

Chart 9: Total General Practitioners, Headcount and FTE, September 2015 to September 2017, England



	Sept 2015	Mar 2016	Sept 2016	Dec 2016	Mar 2017	Jun 2017	Sept 2017
Headcount	41,877	41,985	41,865	41,589	41,891	41,564	41,324
Full-time Equivalent	34,592	34,914	34,495	34,126	33,921	33,560	33,302
Percentage FTE to HC	83	83	82	82	81	81	81

(Source: NHS Digital, 'General and Personal Medical Services, England As at 30 September 2017, Provisional Experimental Statistics', 21 November 2017, tables 1a and 1b. Includes Registrars, Retainers and Locums. Figures for September are provisional.)

The headcount number of FTE GPs has decreased by 541 between September 2016 and September 2017, whilst GP FTEs have decreased by 1,193 over the same period. This indicates that whilst the number of GPs has fallen in terms of headcount, proportionately fewer GPs are also working full time hours.

5.3 Wales, Scotland and Northern Ireland

Data on the number of staff employed by the NHS in the devolved administrations is available from the resources below:

- Welsh Government, 'Staff Directly Employed by the NHS', 29 March 2017
- Information Services Division, National Services Scotland, *NHS Scotland Workforce Information: Quarterly update of Staff in Post and Vacancies at 30 June 2017*, 5 September 2017
- Northern Ireland Department of Health, *Health and Social Care Northern Ireland Quarterly Workforce Bulletin June 2017*, 2 November 2017

6. Further Information

- NHS Digital, *NHS Staff Earnings Estimates: Estimates to June 2017, Provisional Statistics*, 21 September 2017
- Health Education England, *Stepping Forward to 2020/21: The Mental Health Workforce Plan for England*, July 2017
- NHS Improvement, *Evidence from NHS Improvement on Clinical Staff Shortages: A Workforce Analysis*, February 2016
- Royal College of Nursing, *Safe and Effective Staffing: Nursing Against the Odds*, 29 September 2017
- Royal College of Nursing, *Safe and Effective Staffing: The Real Picture*, 12 May 2017
- Full Fact, 'Spending on the NHS in England', 8 November 2017
- King's Fund, *Understanding Pressures in General Practice*, May 2016
- House of Commons Library, *The Structure of the NHS in England*, 7 July 2017
- House of Commons Library, *NHS Staff From Overseas: Statistics*, 18 October 2017
- House of Lords Library, *Leaving the European Union: NHS and Social Care Workforce*, 18 November 2016