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Creative solutions to London's NHS workforce challenges

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In Capital Health?

Creative solutions to London's NHS workforce challenges

JAMES BUCHAN, BELINDA FINLAYSON AND PIPPA GOUGH

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Summary

Taking a fresh look at the NHS workforce in London...

The challenges facing London's NHS workforce are complex and growing. In common with other workforces across the NHS, it must deliver the national targets set out in the NHS Plan. But staff shortages are more pronounced in the capital than in most other parts of the UK, and the demand for health care services for the 7 million people in the capital is likely to increase. By 2016, London's population is predicted to grow by 700,000. The NHS in London must also meet the different health care needs of a wide range of communities, and attempt to reduce health inequalities between them.

On the national stage, the Government is taking action to increase staffing and strengthen workforce management. The Department of Health has launched a series of human resource initiatives ranging from creating new roles, to improving staff motivation and retention. These are to be welcomed, but there is a need to recognise that London faces particular challenges that may need tailored solutions. Some of these challenges are common elsewhere in the NHS but more pronounced in London, such as the need for better use of temporary staff. Others are more specific to the capital, such as the need to recruit from and manage a young, transient and international pool of staff.

Many of the trends that make the capital so different from the rest of the NHS are unavoidable. New policies are needed to manage these distinctive dimensions creatively, rather than trying to fight them. The scale of the challenge facing the NHS workforce in London is huge, but so too are its resources and capacity. How best to harness this capacity remains the crucial question.

This policy paper aims to take a fresh look at the dimensions and dynamics of London's health care workforce, and to tease out some of the opportunities – as well as the challenges – facing London's NHS staff, planners, policy makers and managers. It has been developed with the support of London's five NHS workforce development confederations (WDCs) and the network of human resource managers (SHRINE). Its overwhelming message is that many of the trends facing the NHS in London cannot be prevented, but must be managed. Approaches that go with the grain of wider patterns, rather that cut across them, will have a much greater chance of success.

... and in the NHS as a whole

The message of thinking laterally about workforce challenges is one that can also be of great use to the NHS as a whole. There is broad consensus that the NHS needs more staff. An improved pay and career structure is an obvious solution, but there are less obvious options, such as flexible contracts for older staff, that can help plug the gap and create a rich diversity within the workforce, which will bring benefits to the NHS and the wider community.

Ten challenges

Working within national funding and human resource policy frameworks, London's NHS planners, policy makers and managers must now work in new ways to ensure the sustainable growth in services – and quality improvements – required of them. To do this, they will need to identify and pursue the solutions that work best for London.

In Capital Health? identifies ten key challenges:

Managing staff turnover. The turnover of NHS staff in London is higher than the national average, especially among inner-city and teaching NHS trusts. For example, turnover for allied health professionals (physiotherapists, chiropodists and so on) in London is one-quarter higher than the England average. Some turnover is unavoidable, and helps to bring new blood into the NHS. But high levels can demoralise staff and affect the quality of patient care. High turnover in London reflects the dynamics of its labour market, but these dynamics are poorly understood.

Managing vacancies. Vacancy rates in London are much higher than in the rest of the NHS and vary significantly within London, and between health care professions. For example, the average London vacancy rate (post vacant for three months or more) in 2002 for qualified nurses and midwives was 6.1 per cent (equivalent to 2,750 vacant posts in the capital) – twice the national average. But the rate varies from 3.4 per cent to 10 per cent across London.

Recruiting new staff. People come to London from across the UK and from overseas to train and work as health care professionals, but many leave the capital after qualifying. For example, a survey showed that only one-fifth of the students who graduated from London medical schools in 1995 were still living in London in 2002.

Recruiting experienced staff from elsewhere in the UK. Recruiting new employees from outside London is essential to reduce high staff turnover, fill vacancies and make the best use of skills and experience. Barriers include the high cost of living in the capital, especially the cost of housing.

Recruiting staff from abroad. London relies on recruiting health care workers from abroad much more than the rest of the UK. Twenty-eight per cent of London nurses on the UK nursing register in 2002 were from overseas, compared with around 8 per cent for the UK as a whole. Although international workers are a much-needed labour source, there are ethical considerations to recruiting overseas staff, especially those from developing countries. However, one source of overseas staff is still underused – foreign health care workers already living in the UK as refugees. London must also be aware that many of its international staff are mobile. In a global market place for English-speaking health professionals, London is also at risk of losing its staff to other countries.

Retaining staff. While retaining staff is vital for the stability of London's NHS workforce, keeping experienced and qualified health care staff in the capital is difficult. As with recruiting staff from elsewhere in the UK, the high cost of living in the capital is a barrier. Employers in other parts of the UK may be beginning to exploit this. For example, in May 2003, Edinburgh City Council announced a £1 million advertising campaign on the London Underground to attract key workers to the Scottish capital. More generally, good practice in human resources management is an important factor in motivating staff, but a 2001 survey of staff in London NHS trusts found significant variation in practice.

Attracting staff back. In recent years, the NHS in London has had some success attracting back staff who had left the health service. Since 1999, an average of around 3,700 nurses and midwives have returned to the NHS in England each year. While there is no sign of a national upward trend, London's share of the 'returners' has steadily risen from 9 per cent to 27 per cent. However, there is no comprehensive information on how long returners remain working in the NHS.

Improving the use of temporary staff. London is much more reliant on temporary health care staff – such as agency nurses and locum doctors – than elsewhere in the UK. In 2001–02, the NHS spent more than £220 million on agency nurses in London, a figure that has doubled over the last four years and now represents 40 per cent of the total spend in the NHS in England. The NHS in London must ensure that it controls the cost of using such staff effectively and that the use of agency staff does not adversely affect continuity of care. Unlike other NHS regions, London relies more on agency staff than in-house bank nurses to fill gaps. The wide availability of temporary employment in London means that many 'permanent' NHS staff take on additional jobs – 45 per cent of nurses in the capital have a second job, compared with 28 per cent elsewhere in the UK.

Planning for an older workforce. Although the capital's overall staff profile is younger than the national average, the NHS in London cannot afford to be complacent. Like the rest of the NHS, it must consider imaginative approaches to encourage older employees to continue working, or to support phased retirement. With regard to general practitioners, action is needed to address the high number approaching retirement in the capital. London has proportionately fewer GPs aged between 35 and 49 and more aged over 50 than the national average.

Ensuring equal opportunities and widening entry routes. London's NHS workforce is more ethnically diverse than the national average. However, there are variations between staff groups and data on ethnicity does not exist at all for general practitioners. Employers need to ensure that staffing profiles reflect the ethnic diversity of the catchment population, and provide equal opportunities for members of the local community to enter employment.

Some solutions

These recommendations offer guidelines that planners, policy makers and managers need to consider in a way that capitalises on the distinctive dynamics of the London health care labour market. Workforce development confederations (WDCs) and strategic health authorities (SHAs) have a key role to play in collaborating with other planning agencies.

Develop networks, information and systems for action

- London must develop an effective, city-wide planning and information base for its health care workforce, with good-quality data shared between employers. In primary care, data is needed in relation to all primary care staff, not just GPs.
- The five London-based WDCs have been working to integrate their assessment of the capital's workforce needs, and bring together employers and the education sector. This co-ordinated approach needs further support, as the WDCs merge with strategic health authorities.
- Further investment in human resource planning capacity – including technical skills and change management capabilities – is needed.

Design for transience

- The relatively high turnover of the healthcare workforce in London should be managed by:
    - using temporary staff more effectively
    - encouraging job growth instead of forcing staff to move to develop their careers
    - supporting career structures and rotation schemes that support this high turnover in a way that better meets staff and organisational needs.
- National NHS targets for staff turnover should be re-assessed for their appropriateness to the London context.)

Keep staff who have left connected to employers and the NHS in London

- Employers need to recognise that career breaks, sabbaticals and study leave are normal career aspirations for many health care workers, rather than signs of disloyalty or 'problems'.
- National NHS policy focuses on getting people to return to practice, but potential returners also need to be kept informed, interested and connected to London-based practice while they are away.
- Flexible employment practices and pension schemes need to be developed to support workers through and beyond breaks in their employment, and keep them connected to the NHS for as long as they wish.

Develop a more effective and adventurous approach to attracting and keeping staff within the NHS

- Innovative, practical and effective human resource practice in London – and beyond – should be identified, analysed and replicated, and efforts made to overcome organisational barriers to innovation.
- National targets, policies and initiatives should be reviewed to ensure that they are aligned with key staffing objectives in the capital, and encourage innovation in ways of working and good practice in human resources (HR).

Exploit the appeal of London

- Although living and working in London is often viewed negatively, it can also be marketed as the gateway to an exciting life in a dynamic and culturally diverse city. The attractions of living in the capital should be emphasised to create a more positive image of the variety of careers in health care.
- London's size and scope means it can offer some of the best health care training and career opportunities in the world. It boasts economies of scale not available to any other health region in the UK, and can offer an exciting range of pre- and post-basic training. Part of the 'branding' of London should be to publicise these opportunities.

Involve the whole population in the NHS workforce

- London must invest more resources and effort in 'growing its own' health care workforce, and exploit the specific opportunities opened up by, for example, urban regeneration and a significant pool of skilled refugees.
- London will always rely, to some extent, on attracting new workers from elsewhere in the UK and abroad, but it must improve access from its own communities, on the grounds of both efficiency and equality. This means removing the current barriers – real or perceived – to health care employment and creating new entry points appropriate for London's local populations.
- Health care employers should work closely with the WDCs and SHAs to develop a better understanding of the capital's local labour markets.

Introduction

The challenges facing London's health service are complex. The population of the capital is likely to grow by 700,000 by 2016 (Mayor of London 2002) and there are significant health inequalities between London's diverse communities (Barer *et al* 2003).

A well-trained and motivated workforce is essential to meeting the health care needs of London's population, and to expanding and improving the capital's health services. The NHS in London already employs more than 142,000 people. The NHS Plan (Department of Health 2000a) targets and service needs indicate this number will have to grow over the next decade. Not only will more staff be needed, but these staff will have to work differently: for example, by developing new roles and working together in multi-disciplinary teams.

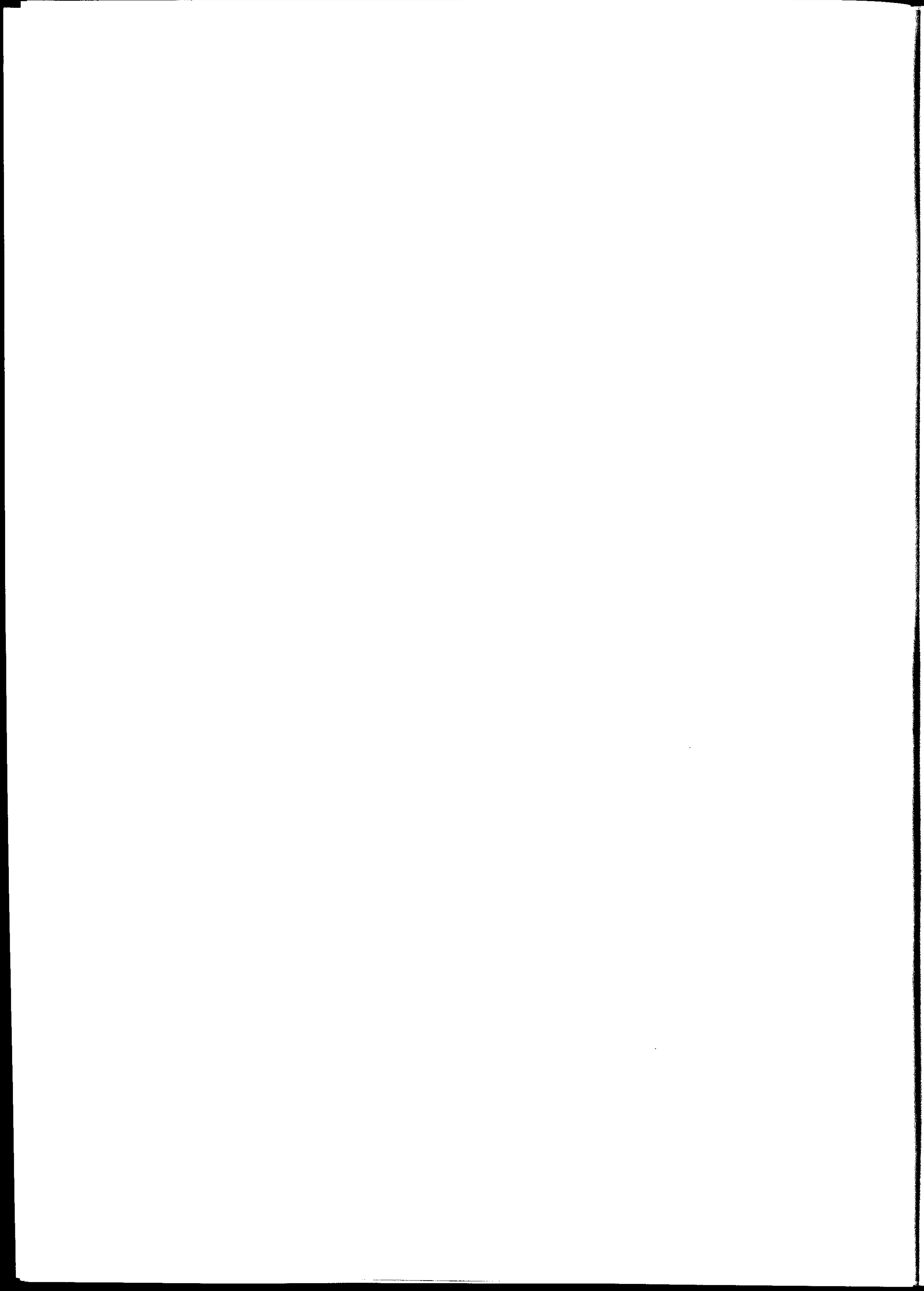
However, staff turnover and shortages are already more pronounced in London than in most other parts of the NHS. As this policy paper shows, for example, vacancy rates in London are reported to be twice as high as the NHS average for some occupations.

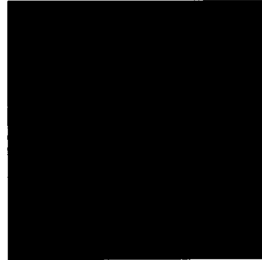
The Government and others are taking action. The Wanless report into the future of the NHS stressed that 'the UK does not have enough doctors and nurses' (HM Treasury 2002). The Department of Health has launched a series of national human resource initiatives, summarised in the NHS Human Resources (HR) Strategy published in 2002 (Department of Health 2002d), which addresses issues of staff retention, motivation, changing working practices and recruitment.

These national initiatives are to be welcomed but, as this policy paper highlights, London is facing numerous challenging workforce trends, some of which are specific to London, such as a young, transient and international staff pool, while others are common throughout the NHS but more pronounced in London, such as the shortage of affordable homes. Policies are needed that acknowledge the distinctiveness of the London labour market and support a strategy for sustainable growth in the capital's health care workforce.

This policy paper aims to take a fresh look at the capital's health care workforce. It identifies ten key challenges and then considers the opportunities and existing initiatives that can be used to address them. The workforce challenges are closely interlinked, requiring coherent planning and collective working by all parties across London. As well as being supported by the five London NHS workforce development confederations (WDCs) and the King's Fund, this work is informed by a steering group that also includes members of the network for London NHS human resource managers (SHRINE), health professional associations and unions, the Department of Health, the former Directorate of Health and Social Care, London, and representatives from the education sector.

The policy paper's overwhelming message is that many of the trends affecting the health care workforce that make London so different from the rest of the NHS cannot be prevented – they have to be managed. Policies aligned with these dynamics, rather than cutting across them, will have a much greater chance of success. The scale of the challenge facing the NHS workforce in London is huge, but so too are its resources and capacity. This policy paper explores how best to harness that capacity.

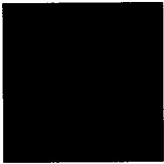


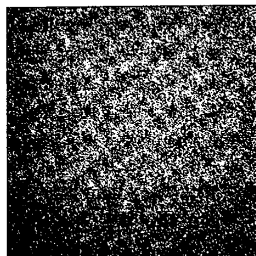


Part one

Measuring the challenges

Across the UK, the health care sector is facing recruitment and retention challenges. These challenges are most severe for health care employers in London, where staff turnover and vacancy rates are much higher than the UK average. Part one of this paper identifies these challenges and, in analysing them, highlights that the inherent career advancement opportunities of employment in London can be too easily undermined by cost-of-living factors.





Background

The NHS in London employs more than 142,000 staff, representing approximately one in six of all staff in the NHS workforce nationally. While these staff are employed by individual NHS trusts and primary care trusts (PCTs), the responsibility for workforce planning, monitoring and commissioning training places is held by the workforce development confederations (WDCs).

There are five London-based WDCs: North East London WDC, North West London WDC, North Central London WDC, South East London WDC and South West London WDC. Table 1 (*see opposite*) provides an overview of the current NHS workforce in London, drawing from data provided by the five WDCs.

The NHS in London employed more than 142,000 staff in March 2003. Qualified nursing and midwifery staff comprised the biggest group, with almost 50,000 being employed; there were also 20,000 qualified allied health professionals and other qualified scientific, therapeutic and technical staff, and 40,000 administrative and estates staff. This is the best picture that can be determined given limitations in data.

London is a major employer of NHS staff, and as such it has to take account of all relevant national policy initiatives. Key current initiatives include:

- All NHS organisations in England have to participate in the Improving Working Lives (IWL) accreditation process. This sets out a series of linked HR practices, covering flexible working, healthy working, access to training, childcare provision and staff involvement (Department of Health 2000b).
- At the time of writing, the first NHS trusts are implementing Agenda for Change, a new pay and career structure for all non-medical NHS staff. It is based on a single job evaluation system for all groups and occupations. Agenda for Change will retain a national pay framework, but will offer greater flexibility for individual jobs to be 'priced'. There is a mechanism for pay supplements in regional labour markets in which recruitment and retention of staff is more difficult (Department of Health 2003). Related to Agenda for Change are the development of a Knowledge and Skills Framework and a 'skills escalator', a framework linking grades and occupations that will give individual NHS staff greater opportunities to plan their career. This should enhance access to NHS employment opportunities and facilitate career progression.
- The Changing Workforce Programme (CWP) (Department of Health 2002d) is the focal point for government-led initiatives to encourage new roles and new skill mixes in the NHS in England. Local pilot sites have been set up to enable a variety of innovative ways of staffing to be evaluated, many based on care protocols or pathways.

The remainder of this part of the policy paper details the ten key challenges that face those responsible for planning and managing London's NHS workforce.

TABLE 1: THE NHS WORKFORCE IN LONDON, 31 MARCH 2003

	North West London WDC		North Central London WDC		North East London WDC		South West London WDC		South East London WDC		London total	
Staff group	**Headcount**	**WTE**	**Headcount**	**WTE**	**Headcount**	**WTE**	**Headcount**	**WTE**	**Headcount**	**WTE**	**Headcount**	**WTE**
Qualified allied health professionals	1,956	1,725.22	1,568.00	1,353.29	1,267.00	1,125.57	1,176.00	975.04	1,613.00	1,421.29	7,580.00	6,600.41
Other qualified scientific, therapeutic and technical staff	2,876	2,549.66	2,382.00	2,055.96	1,949.00	1,738.49	1,165.00	963.87	2,666.00	2,365.97	11,038.00	9,673.95
Technicians			580.00	546.52			642.00	574.05			1,222.00	1,120.57
Other scientific, therapeutic and technical staff, unqualified	839	728.45	516.00	484.03	831.00	709.58	66.00	65.35	864.00	745.29	3,116.00	2,732.70
Qualified nurse and midwifery	12,589	11,568.82	9,919.00	9,157.15	8,023.00	7,454.78	7,362.00	6,294.36	11,267.00	10,042.97	49,160.00	44,518.07
Nursery nurse	92	86.59	56.00	50.88	87.00	72.73	103.00	88.60	110.00	98.45	448.00	397.25
Nursing assistant/auxiliary	1,751	1,648.24			1,653.00	1,466.50			1,398.00	1,269.06	4,802.00	4,383.80
Healthcare assistant and support staff	2,432	2,158.15	3,173.00	2,936.54	2,690.00	2,370.38	3,109.00	2,705.16	2,656.00	2,517.05	14,060.00	12,687.27
Administrative and estates staff	9,711	8,384.42	8,241.00	7,576.20	7,421.42	6,320.00	6,009.00	5,185.09	8,465.00	7,354.04	39,847.42	34,819.76
General practitioners	356	289.94	861.00	757.68	966.00	879.50	398.00	361.46	916.00		3,497.00	2,288.58
Consultants	1,662	1,275.47	1,590.00	1,159.20	999.00	832.95	813.00	673.62	1,451.00	952.29	6,515.00	4,893.53
Staff grades, associate specialists, clinical fellows, trust doctors			217.00	177.27	320.00	307.38	182.00	164.81			719.00	649.46
Hospital practitioners, clinical assistants			174.00	57.83	111.00	34.92	167.00	53.31			452.00	146.06
Total number of staff	**34,264**	**30,414.96**	**29,277.00**	**26,312.55**	**26,317.42**	**23,312.78**	**21,192.00**	**18,104.73**	**31,406.00**	**26,766.41**	**142,456.42**	**124,911.43**

Notes:
1) Data supplied by individual WDCs; aggregation based on this data
2) Administration and estates staff includes managers
3) Consultant totals include honoraries and are not adjusted to account for those consultants who hold multiple contracts
4) Does not include ambulance staff
5) Does not include staff in training
6) Does not include regional staff
7) Does not include staff employed in GP practices, except where staff are employed directly by a PCT
8) Staff totals for qualified nursing and midwifery do not include bank staff
9) Some WTE data supplied by SEL is incomplete
10) SWL and NCL data on nursing assistants/auxiliaries is included in the data on healthcare assistants and support staff
11) NWL, NEL and SEL data on technicians is incorporated into qualified and unqualified scientific, therapeutic and technical staff
12) NWL does not yet have data on staff grades, associate specialists, clinical fellows, trust doctors, hospital practitioners or clinical assistants

Definitions:
1) 'Qualified AHPs' includes: chiropody, dietetics, occupational therapy, orthoptics/optics, physiotherapy, diagnostic radiography, therapeutic radiography, art/music/drama therapy
2) 'Other qualified scientific, therapeutic and technical staff' includes: speech and language therapy, multi-therapies, clinical psychology, psychotherapy, medical physics, pharmacy, pathology, dental, physiological measurement, operating theatres, social services and other scientific, therapeutic and technical staff
3) 'Technicians' includes: chiropody, orthoptics/optics, diagnostic radiography, clinical psychology, medical physics, pharmacy, pathology, dental, physiological measurement, operating theatres, other scientific, therapeutic and technical staff

Source: The five London WDCs (*see* Note 1, *above*)

The ten key challenges in this policy paper are relevant to all groups in the health workforce. We have used examples to illustrate these challenges. In doing so, we have attempted to cover a representative cross-section of staff groups. However, our ability to do so has been limited by the shortage of data on some staff groups, such as general practitioners and other primary care practice staff.

The ten key challenges are:

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

The ten challenges

Ten key challenges that face those responsible for planning and managing London's NHS workforce are described. These include general issues facing all health care employers, but which are more pronounced in the capital, such as recruiting new staff, turnover of existing staff, high levels of vacancy rates and encouraging returners. Other challenges have a distinct London dimension, such as recruitment from outside the UK, widening entry routes, and managing high levels of temporary staffing.

Managing staff turnover

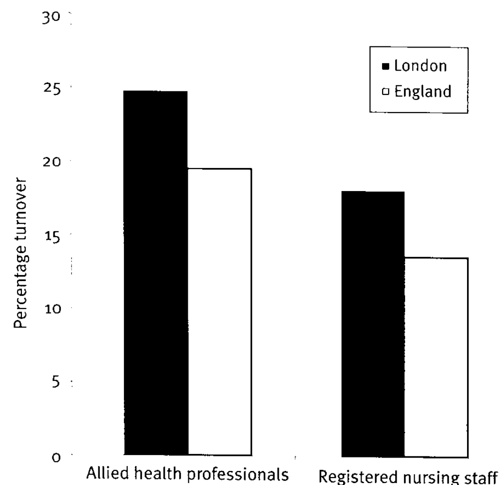
The turnover of NHS staff is higher in London than the average for England, especially among inner city and teaching NHS trusts.

Turnover is an annual measure of the number of employees who have left a post and moved to another NHS organisation, or have left the NHS altogether. Some turnover is unavoidable, and helps to bring new blood into the NHS. However, very high rates can be a significant drain on the service. The Audit Commission (1997) estimated that the average cost of a staff nurse leaving an NHS organisation was £4,900. High levels of turnover can indicate difficulties in recruitment and retention. They may also have a negative effect on patient care and staff morale (Meadows 2000).

The Office of Manpower Economics (OME) conducts annual surveys of the turnover of certain employee groups within the NHS. Its 2001 survey (the most recent available) found that, in England, turnover was 13.5 per cent for registered NHS nursing staff and 18 per cent for NHS allied health professionals (Review Body 2002).

The survey reported significantly higher turnover rates for NHS staff in London (*see* Figure 1, *below*), for example 24.7 per cent for allied health professionals (about one quarter higher than the average for England); and 19.5 per cent for registered nursing staff (about one-third higher than the average for England).

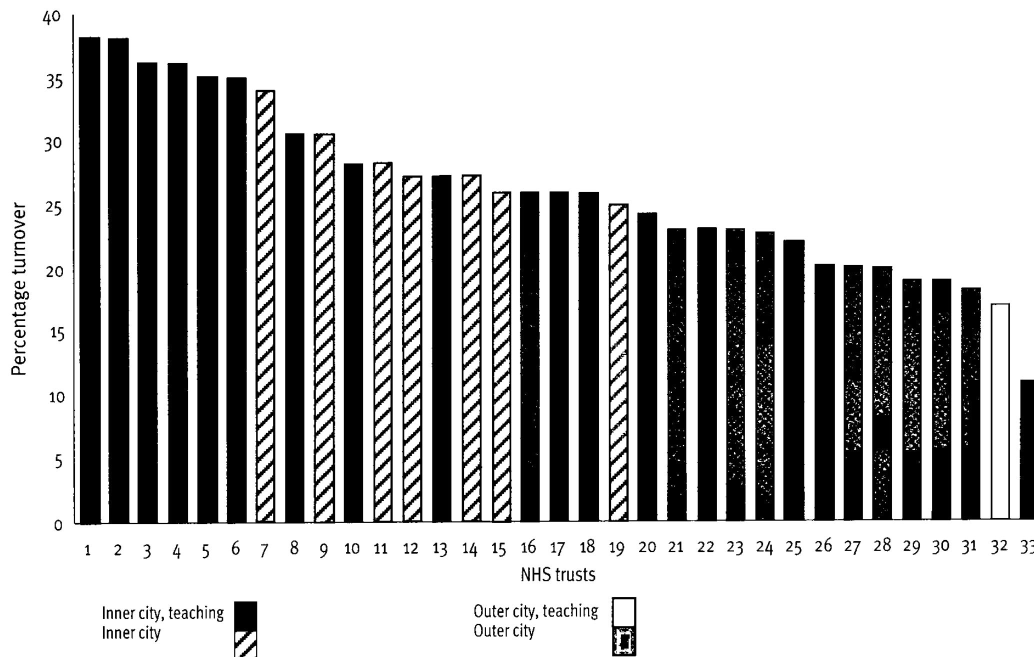
FIGURE 1: TURNOVER RATES FOR ALLIED HEALTH PROFESSIONALS AND REGISTERED NURSES IN LONDON AND ENGLAND, 2001



Note: based on a survey with a response rate of less than 100 per cent
Source: Review Body (2001)

Within London, turnover varies widely between trusts (*see* Figure 2, *opposite*). In 1999–2000, the turnover rates for registered nurses working in adult care ranged from 11 per cent to 38 per cent, with the highest rates occurring among inner-city and teaching trusts (Finlayson *et al* 2002).

FIGURE 2: TURNOVER RATES FOR REGISTERED NURSES (ADULT) IN ACUTE TRUSTS IN LONDON, 1999–2000



Note: Trust No 4 employs less than 100 WTE registered nurses (adult)
Source: Education and Training Consortia, London (2001), reported in Finlayson *et al* (2002)

Of the 33 acute trusts shown in Figure 2, 18 had turnover rates of more than 25 per cent and nine had turnover rates of more than 30 per cent.

The data in Figure 2 illustrates one example of the significant variations in staffing indicators in the NHS that exist between inner and outer London, and also between different organisations within the capital.

High turnover in London reflects the dynamics of its labour market. In order to effectively manage turnover, these dynamics need to be better understood.

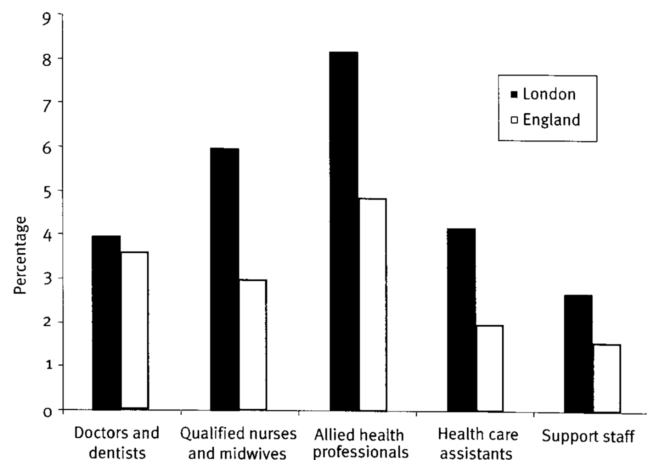
Managing vacancies

Staff vacancy rates in London are much higher than the average for England. They also vary significantly within London and between health care professions.

Funded posts that remain vacant for long periods can indicate recruitment difficulties. Vacant posts often result in a heavier workload for other employees. This can affect morale and lead to higher staff turnover, thus increasing the use of agency staff. This vicious cycle of vacancies and staff shortages may inhibit the delivery of high quality care.

The annual vacancy survey conducted by the Department of Health (2002c) lists all the vacancies that NHS trusts in England have been trying to fill but that have been vacant for three months or more. Vacancy rates for NHS staff in London are much higher than the average for England (*see* Figure 3, *below*). This is true for all main employee groups. For allied health professionals, the rate in London is 8.3 per cent, equivalent to 600 long-term vacancies; for qualified nurses and midwives it is 6.1 per cent, or 2,750 long-term vacancies (twice the national average) and for medical and dental staff it is 4.1 per cent, or 260 long-term vacancies.

FIGURE 3: PERCENTAGE OF NHS STAFF POSTS VACANT AFTER THREE MONTHS IN LONDON AND ENGLAND, MARCH 2002



Note: based on a survey with a response rate of less than 100 per cent
Source: Department of Health 2002c

Vacancy rates for most employee groups have increased since 2001, with the exception of qualified nurses.

There are also significant variations in vacancy rates within London (*see* Table 2, *opposite*). The rates for all London health authorities exceed the national average, some by up to three times. In Barnet, Enfield and Haringey Health Authority, one in ten nursing and midwifery posts have been vacant for at least three months.

TABLE 2: THREE-MONTH VACANCY RATES FOR QUALIFIED NURSES AND MIDWIVES, MARCH 2002

Area	Percentage
England	3.1
London	6.1
Barking and Havering HA	5.6
Barnet, Enfield and Haringey HA	10.0
Bexley, Bromley and Greenwich HA	6.8
Brent and Harrow HA	3.8
Camden and Islington HA	6.0
Croydon HA	3.5
Ealing, Hammersmith and Hounslow HA	3.9
East London and the City HA	4.5
Hillingdon HA	3.4
Kensington, Chelsea and Westminster HA	5.5
Kingston and Richmond HA	6.8
Lambeth, Southwark and Lewisham HA	9.7
Merton, Sutton and Wandsworth HA	3.4
Redbridge and Waltham Forest HA	6.0

Source: Department of Health (2002c)

Official vacancy rates, estimated as a 'snapshot' at one point in the year, may underestimate the actual number of vacancies. Furthermore, some vacancies may reflect the current funded expansion of NHS posts, which employers have, as yet, been unable to fill.

High levels of vacancies have to be addressed if the potentially negative impact on other staff and on patient care is to be minimised.

Recruiting new staff

People come to London from all over the UK and from overseas to be trained or work as health care professionals – but many of them leave the capital within a short time of qualifying.

Instead of being an 'exporter' of new and recent graduates, London needs to retain more of them. Understanding where these students and staff come from, and how long they stay, is now a priority.

As part of its annual survey of medical school graduates, the British Medical Association (BMA) collects data on where doctors live. In 2002, only 21 per cent of the students who graduated from London medical schools in 1995 were still living in London. Most of the remainder were living in central or southern England (BMA 2002).

Table 3 (*below*) shows data from the Nursing and Midwifery Admissions Service, which processes all applications for diploma based nursing and midwifery courses in England. In 2002, almost one in three (32 per cent) of diploma-based student nurses accepted for training in London were living outside the capital when they applied.

TABLE 3: PERCENTAGE OF ACCEPTED NURSING DIPLOMA APPLICANTS BY REGION OF DOMICILE AND REGION OF INSTITUTION IN ENGLAND, 2002

Region of domicile*	London	South west	South east	Eastern	West Midlands	Trent	North west	North/York
London	68	1	9	6	1	1	0	0
South west	3	65	6	1	2	1	0	1
South east	13	25	67	10	2	2	1	1
Eastern	6	1	4	72	1	2	0	1
West Midlands	1	1	3	1	82	3	1	0
Trent	2	1	1	3	4	86	2	9
North West	1	1	1	1	2	1	82	3
North/York	2	0	1	1	1	3	8	84
Wales	0	1	1	0	1	0	2	0
Scotland	0	0	0	0	0	0	0	0
Northern Ireland	0	0	0	0	0	0	0	0
Eire	1	0	0	0	0	0	0	0
Other EEA**	2	2	2	3	2	2	2	1
Outside EEA	1	2	5	2	2	1	0	0
Not known	0	0	0	0	0	0	0	0
Total number of students	**1,503**	**2,012**	**1,462**	**1,162**	**2,012**	**2,082**	**3,143**	**2,184**

* At time of application

** Countries of the European Economic Area

Note: Some figures do not add up to 100 due to rounding

Source: Nursing and Midwifery Admissions Service 2003

The London WDCs and strategic health authorities (SHAs) need to consider how to use all available entry routes to recruit locally based students, who are more likely to stay in London.

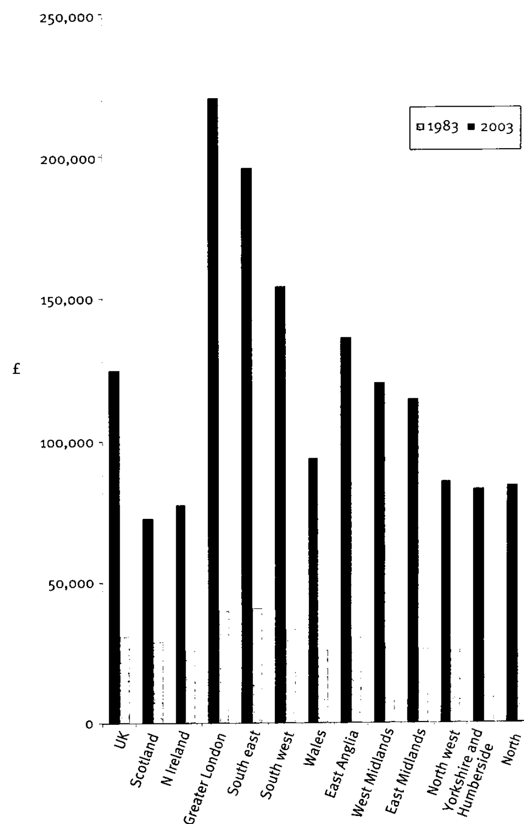
Recruiting experienced staff from elsewhere in the UK

London needs to attract experienced staff from elsewhere in the UK, but the higher cost of living in the capital – especially the property prices – is an obstacle.

Recruiting new employees from outside London is essential to reduce the high staff turnover, fill vacancies and make the best use of skills and experience. However, unlike the rest of the UK, London's health care labour market has to contend with the high cost of living in the capital.

Over the past 20 years, house prices in London and the south east have risen much more rapidly than elsewhere in the UK (*see* Figure 4, *below*). In 1983, the average house in London cost about £40,000 (around 25 per cent above the national average), but by the first quarter of 2003, the average price in London had risen to £220,525 (almost double the national average). Some employers are trying to attract experienced staff to London by providing subsidised accommodation, and the NHS Plan has a target of an additional 2,000 residential units by 2004. Against this context there is also a need to examine NHS pay rates in the capital. Furthermore, London weighting allowances – a legacy of the 1980s and before – have not kept pace with the huge relative increase in the cost of living in London.

FIGURE 4: AVERAGE HOUSE PRICES IN ENGLAND BY REGION, 1983 AND 2003



Source: HBOS 2003

One way of tackling the problem might be to introduce greater flexibility for setting local or regional pay. This could become possible if the pay reforms proposed in Agenda for Change (Department of Health 1999) are carried out. However, the impact of these reforms will have to be monitored to ensure that they do not distort local labour markets or over compensate some groups or individuals at the expense of others.

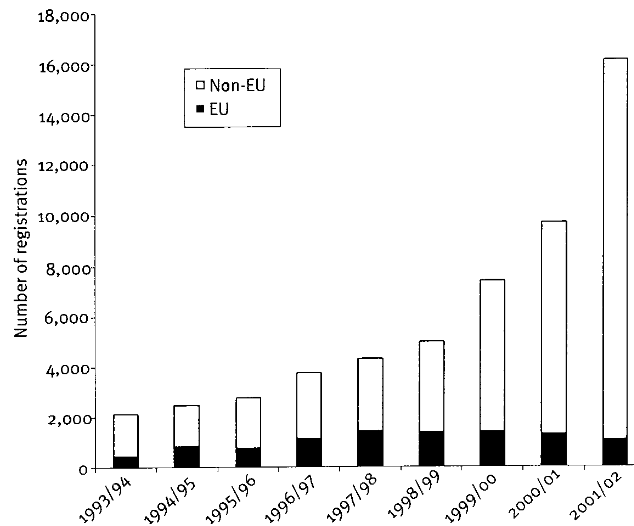
Recruiting staff from abroad

London relies far more than the rest of the NHS on international recruitment of staff, yet it is also vulnerable to having these staff – as well as its 'home-grown' staff – lured away by overseas employers.

Over the past few years, recruiting health care professionals from abroad has offered a relatively 'quick fix' to the problems of recruitment and retention. However, it has been controversial, provoking accusations that the NHS is 'poaching' staff from other countries, especially developing ones.

In 2002, around 8 per cent of nurses on the register of the Nursing and Midwifery Council were from overseas (Buchan 2003). In London, this proportion was around 28 per cent. The inflow of nurses from abroad has increased markedly in recent years (*see* Figure 5, *below*). In 2002 half the new nurses on the register were from abroad, mainly from the Philippines, South Africa and Australia (Buchan 2003).

FIGURE 5: ADMISSIONS TO THE NURSING AND MIDWIFERY REGISTER FROM EU AND NON-EU COUNTRIES 1993–2002 (INITIAL REGISTRATIONS)



Source: United Kingdom Central Council for Nursing, Midwifery and Health Visiting/ Nursing and Midwifery Council (2000), reported in Buchan (2003)

Another source of 'international' recruits is health workers who are already in the UK as refugees or asylum seekers. In the past, this resource of skilled staff has been under-exploited (Greater London Authority 2002), but efforts are now being made to help them into the labour market – for example, by providing refresher training and clinical attachments in NHS trusts. In April 2003, 54 per cent of the 849 doctors on the BMA/Refugee Council database of refugee doctors were based in London. A similar initiative for refugee nurses has been set up at the Royal College of Nursing.

Just as London is reliant on recruiting internationally for health care staff, so it is vulnerable to international competition for these staff. London, with its large pool of internationally mobile health care professionals, is the first place where employers seeking to recruit experienced staff for other English speaking countries will look. The biggest competitor is the United States, where the health sector will need more than three million new jobs by 2010 (Center for Health Workforce Studies 2002), but countries such as Canada and Australia are also recruiting internationally.

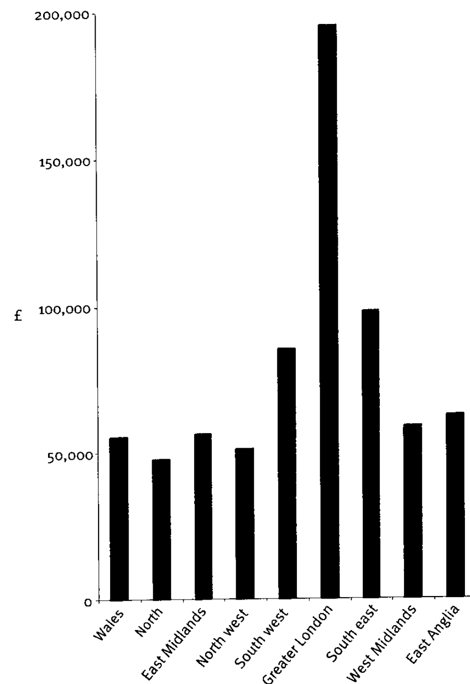
Retaining staff

Keeping experienced and qualified health care staff in London is difficult, partly because of the high cost of living.

Retaining employees is vital for the stability of London's NHS workforce. The training on offer, together with the career opportunities available in its centres of excellence, have helped to attract trainee doctors, nurses and other health professionals to the capital. But many of them cannot afford to stay once they have completed their training. Once more, a key factor is the cost of living, especially housing. As employees move on from rented and shared accommodation and seek to buy a home of their own, they find increasingly that they have to look outside the capital for affordable housing.

On p 12, we looked at average house prices across the UK regions. The regional variations in the price of the typical 'first' home – a flat or a maisonette – are even starker. In March 2003, the average cost of a flat or maisonette in Greater London was £195,500, twice the cost in the next most expensive region (the south east) and more than four times the cost in the north of England (*see* Figure 6, *below*). Assuming that purchasers could obtain a 100 per cent mortgage based on three times their annual income, they would need to be earning £65,000 a year to buy into the London housing market at this price.

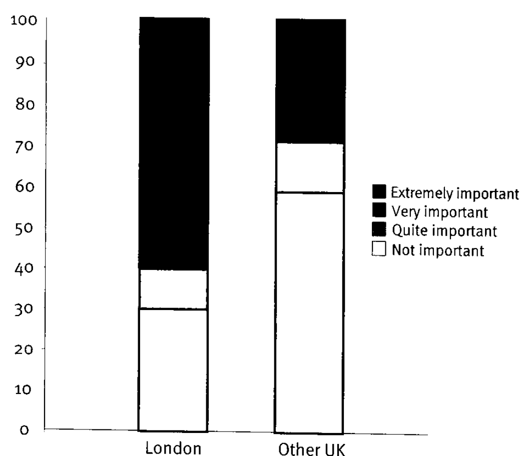
FIGURE 6: AVERAGE PRICE OF A FLAT/MAISONETTE BY REGION, MARCH 2003



Source: Hometrack (2003)

A survey conducted for the Greater London Authority (2001) found that London-based nurses were much more likely than other groups of key workers (such as teachers and the police) to be thinking about finding employment outside the capital. In the survey of members by the Royal College of Nursing in 2001, more than half of the NHS nurses in London said that the availability of affordable housing was 'extremely important' or 'very important' (*see* Figure 7, *below*). Almost two-thirds of nurses elsewhere in the UK said that it was 'not important'.

FIGURE 7: IMPORTANCE OF AFFORDABLE ACCOMMODATION FOR NHS NURSES, 2001



Source: Royal College of Nursing 2001

Providing support for adequate and appropriate housing – for example, by offering subsidies or joint tenures with a housing association – can help employers retain, as well as recruit, staff in London.

The NHS in London has to be aware that the lack of affordable and appropriate housing provides an opportunity for health care employers in other parts of the UK to exploit this negative aspect of living and working in the capital, and they may attempt to recruit London-based health workers. For example, in May 2003, Edinburgh City Council announced a £1 million advertising campaign on the London Underground to encourage key workers, such as nurses, to move from London to the Scottish capital (Black 2003).

The Department of Health is now placing greater emphasis on staff retention across the NHS; its Improving Working Lives (IWL) initiative aims to keep staff motivated by, for example, providing opportunities for flexible working. Also, there is growing evidence to link good practice in managing human resources with staffing characteristics and outcomes of care (Buchan 2002b). A survey of 34,400 staff in 59 NHS trusts in London in 2001 found that better management made a difference to their motivation, but that there was significant variation between trusts (Perryman and Robinson 2003). This reinforces the fact that there is potential to improve the commitment of NHS staff in London, although the survey also found a general dissatisfaction with pay and with the lack of appraisal and development opportunities.

It is important to identify the 'good' NHS employers in the challenging London labour market, and to ensure that their practices are more widely applied across the capital.

As noted earlier, the NHS in London also needs to 'grow its own' staff by tapping into local labour markets. Increasing the proportion of employees who are recruited locally is likely to improve workforce stability.

Attracting staff back

The NHS in London has had some success in attracting back staff who had left, but how large the pool of potential 'returners' is, and how long they might stay in the NHS, is difficult to establish.

The Department of Health has run a series of annual campaigns to attract back employees who have left the NHS. Table 4, *below*, shows that in recent years an average of about 3,700 nurses, midwives and health visitors have returned to the NHS in England each year. There is no sign of a national upward trend, but London's share of returners seems to have been rising over this period.

TABLE 4: NUMBER OF NURSES AND MIDWIVES WHO HAVE RETURNED TO WORK IN THE NHS IN LONDON AND ENGLAND, 2002

	London	England	London as a % of total
1999–2000	258	3,034	9
2000–01	561	4,479	13
2001–02	738	3,763	20
April–September 2002	500	1,864	27

Note: Based on data from WDCs – does not relate specifically to Return to Practice (RTP) courses
Source: Written answer to parliamentary question, 3 April 2003

These Department of Health figures do not show how many returners stay on in the NHS after completing Return to Practice courses, or how many other returners are not recorded centrally. The parliamentary written answer that provided the data for Table 4 also reported: '86 per cent of people that had completed a Return to Practice course in the last three years had returned to and remained in practice.'

Between April 2001 and March 2002, the number of returners in London totalled 738 nurses and midwives and 106 allied health professionals, scientists and technicians. Further targets were set for 2002–03 (*see* Table 5).

TABLE 5: RETURNERS TO LONDON NHS IN 2001–02, AND TARGETS FOR 2002–03

	Nurses	Midwives	Allied health professionals and scientists and technicians
2001–02	687	51	106
2002–03	1310	199	199

Source: The London Modernisation Board (2003)

These statistics cover only Return to Practice schemes: they do not include 'informal' returners, or indicate what proportion may be working part-time.

In 2001–02, data from the WDCs in London showed that 158 locally resident, overseas-trained health professionals were taking a supervised practice course as part of their entry into NHS employment. Some of these staff may have been refugees (Greater London Authority 2002).

There is no comprehensive information on how long returners stay working in the NHS, and this limits our ability to assess the effectiveness of these initiatives. If the NHS in London's is to maximise the benefit from attracting back these returners, it will have to tackle retention, as some of these 'returners' may leave again if they are not offered adequate support.

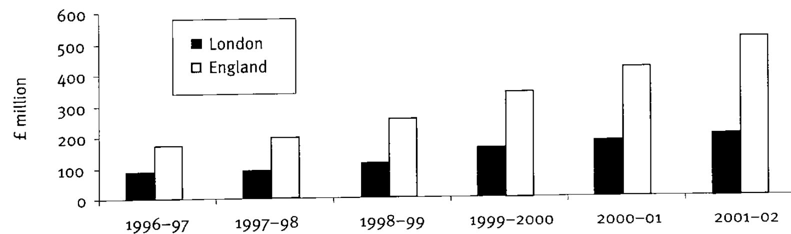
Improving the use of temporary staff

London is much more reliant on temporary health care staff than elsewhere in the UK. The NHS plans to provide a higher proportion of these staff through its own in-house agency – NHS Professionals.

The NHS uses temporary staff – such as agency nurses and locum doctors – not only as short-term cover for permanent staff who are on leave or sick, but also to cover for longer-term vacancies. Heavy reliance on temporary staff can indicate difficulties with the recruitment and retention of permanent staff. It also raises questions about the cost-effectiveness of employing high levels of temporary staff and the impact on continuity of care.

Expenditure on temporary staff has grown significantly in recent years. Figure 8, *below*, shows that, in 2001–02, the NHS spent more than £220 million on agency nurses in London, a figure that has doubled over the last four years and now represents 40 per cent of the total expenditure on agency staff for England. About 200,000 nursing shifts every month are covered by temporary staff.

FIGURE 8: NHS EXPENDITURE ON AGENCY NURSING STAFF IN LONDON AND ENGLAND, 1996–97 TO 2001–02



Source: Hansard, written answers, 28 March 2003, column 443W; 7 November 2002, column 538W

A 2001 Audit Commission survey found that in non-teaching hospitals in London, expenditure on agency staff was an average 11 per cent of the nursing pay bill, compared with only 3 per cent in the equivalent NHS trusts outside London.

The Audit Commission reported that London was the only NHS region where more was spent on agencies than on in-house NHS nurse banks. The Commission reported that temporary nursing staff in London non-teaching hospitals accounted for between 2 and 29 per cent of the total nursing pay bill. The larger number of vacancies was another reason given for the greater use of agency staff. Pay rates for agency nurses were higher in London than elsewhere (Audit Commission 2001).

Many 'permanent' NHS staff in London take on additional temporary work, which may enable some to carry on living and working in the capital. The 2002 membership survey by the Royal College of Nursing (RCN) found that 45 per cent of nurses in the capital have a second job, compared with 28 per cent elsewhere in the UK. In previous membership surveys (*see* Seccombe and Smith 1997), the RCN found that most nurses who took second jobs did so to increase their income.

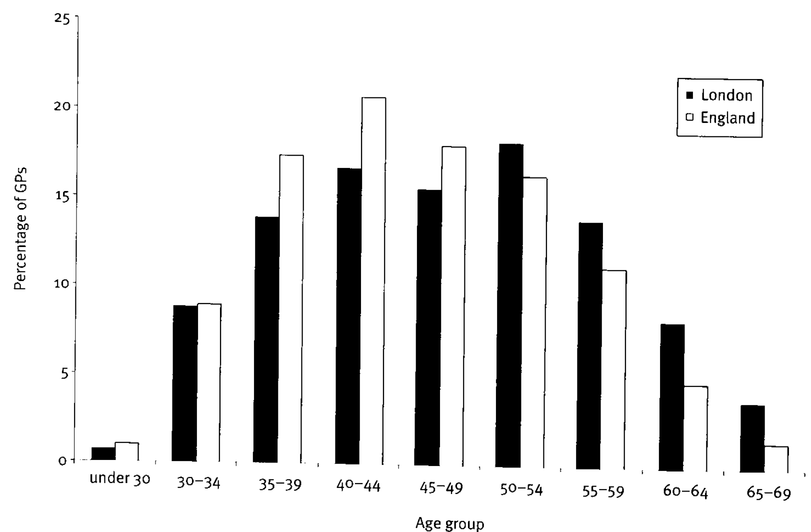
To reduce its reliance on external agency staff, the NHS in England has tried to set up its own national in-house agency – NHS Professionals. Initial attempts have not been entirely successful, and NHS professionals is being reorganised. Meanwhile, the NHS in London has established its own agency project to try to control more effectively the costs of using agency staff.

Planning for an older workforce

With the exception of general practitioners, the age profile of NHS staff groups in the capital is generally younger than the national average.

While it generally has a younger age profile of staff, NHS workforce planners in London have to take account of the ageing of many occupational groups, for example, general practitioners (Meadows 2003). The capital has proportionately fewer GPs aged between 35 and 49 and more aged over 50 than the national average (*see* Figure 9, *below*). The large number of GPs recruited from south Asia to the UK in the 1970s are now nearing retirement. In some areas, especially London, this could mean the loss of one in four GPs over the next few years (Taylor and Esmail 1999).

FIGURE 9: AGE PROFILE OF THE GENERAL PRACTITIONER WORKFORCE IN LONDON AND ENGLAND, 2001

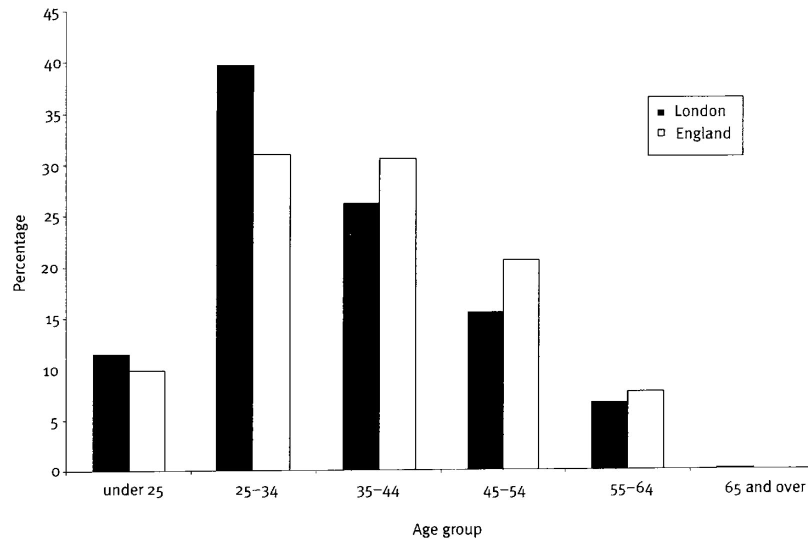


Source: General Practitioner census 2001 (Department of Health, 2002b)

Within London, there are variations in the age profile of GPs. Many of the London GPs approaching retirement work in small partnership or single-handed practices, often in deprived inner-city areas where vacancies may be more difficult to fill.

The allied health professions in the capital have a much younger profile than the average for England (*see* Figure 10, *opposite*). London employs proportionately more allied health professionals aged between 25 and 34 than England as a whole, and proportionately fewer aged over 35.

FIGURE 10: AGE PROFILE OF ALLIED HEALTH PROFESSIONALS IN LONDON AND ENGLAND, 2001 (AS A PROPORTION OF ALL STAFF IN EACH STAFF GROUP)



Source: Statistical Bulletin: 2002/02 (Department of Health, 2002a)

London also has more nurses aged 25–34 and fewer aged 35–44 than the national average.

NHS employers, WDCs and SHAs have to fully understand the implications of the differing age profiles within the NHS workforce and of the varied impacts that national policies aimed at the ageing workforce might have. This may require more imaginative approaches in London to recruitment and retention, for example incentives to encourage older employees to continue working, or to support phased retirement (Meadows 2003).

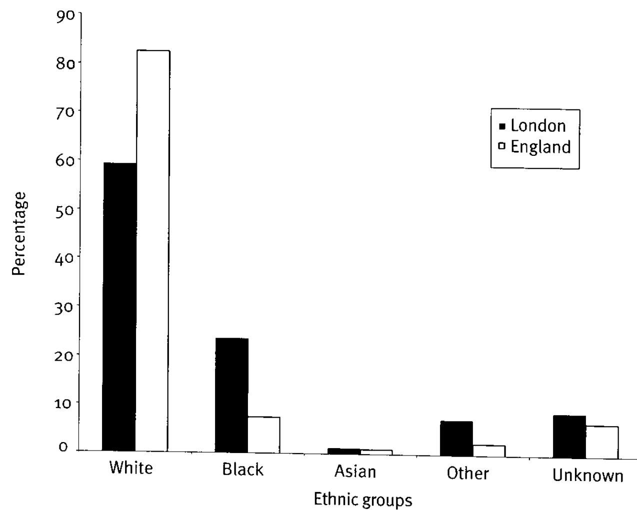
The impact of ageing may be more pronounced initially in other parts of the country but London must not be complacent. The need to replace retired staff will increase recruitment competition across the NHS.

Ensuring equal opportunities and widening entry routes

London's NHS workforce is more ethnically diverse than the national average. It must provide accessible employment opportunities to ensure its workforce is representative of its local population.

Student nurses, midwives and health visitors in London are more ethnically diverse than the average for England (*see* Figure 11, *below*); a smaller proportion is classified as white, and larger proportions are classified as black or of 'other' ethnicity.

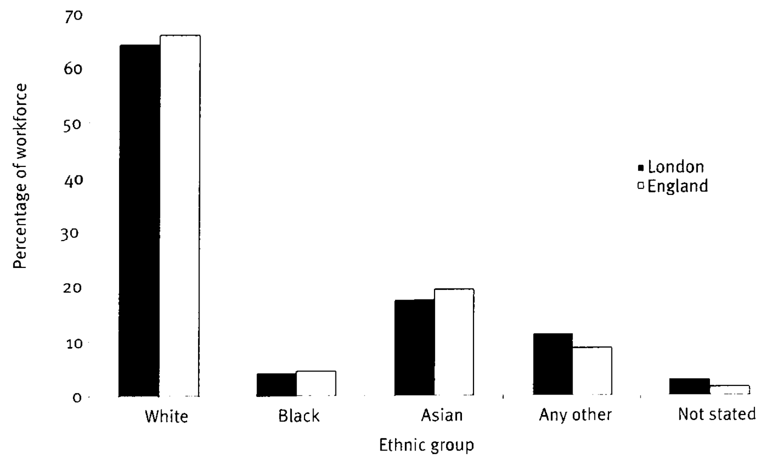
FIGURE 11: ETHNIC COMPOSITION OF NURSING, MIDWIFERY AND HEALTH VISITING LEARNERS IN LONDON AND ENGLAND, 2000



Note: Based on a survey with a response rate of less than 100 per cent
Source: Department of Health (2001a)

The ethnic composition of the NHS medical and dental workforce in London appears to be much closer to the national average (*see* Figure 12, *opposite*).

FIGURE 12: ETHNIC COMPOSITION OF THE MEDICAL AND DENTAL WORKFORCE IN LONDON AND ENGLAND, 2000

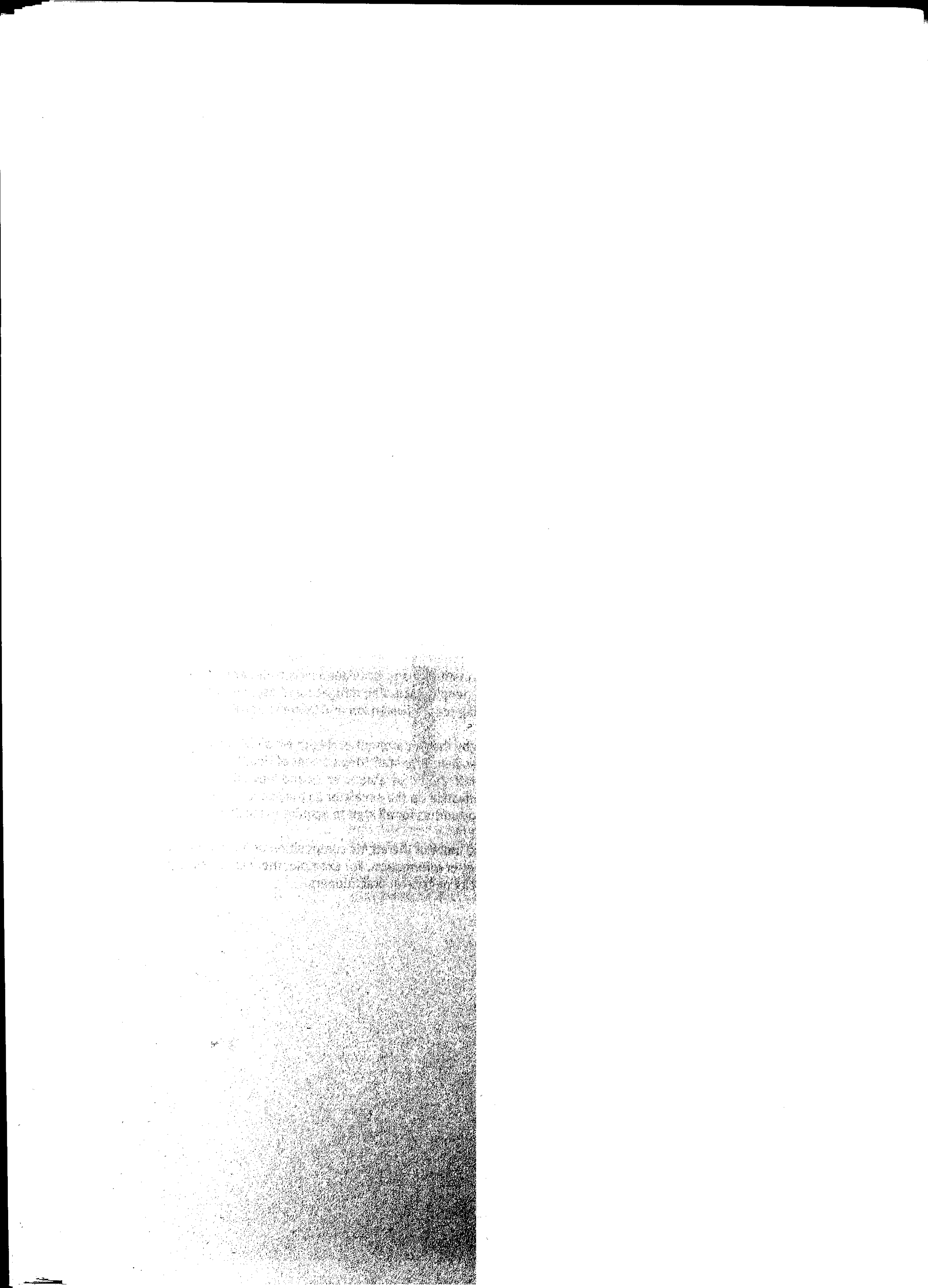


Source: Department of Health (2001a)

A workforce that is representative of the local population is one of the criteria NHS employers have to meet to achieve 'Improving Working Lives' accreditation (Department of Health 2000b). Doing so involves more than just ensuring that the current staffing profile reflects the ethnic diversity of the catchment population. It also means providing equal opportunities for members of the local community to enter the workforce. This emphasis on 'growing your own' staff may require employers and educational institutions to consider new recruitment strategies that make it easier for local people, including refugees and asylum seekers, to apply for local jobs or training places (Levenson and Edmans 2001).

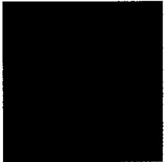
This connects with the plan by the Department of Health for all NHS employers to provide a 'career skills escalator' for staff (Department of Health 2002d). According to these plans, staff should be able to enter and leave the escalator at any point, as well as to advance up the escalator as they acquire more skills. There should be equal opportunities for all staff to acquire these skills.

However, if employers are to monitor the ethnic composition of their workforce effectively, they will need better information. For example, there is currently no data available on the ethnicity of general practitioners.

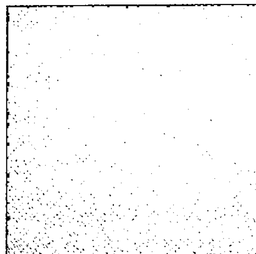


Part two

Meeting the challenges



This policy paper has identified ten inter-related challenges that the NHS workforce in London faces. This part begins to explore how to meet these challenges. It summarises the solutions proposed at two workshops, held in October 2002 and May 2003, that were attended by members of London's health workforce and by people involved in workforce policy, planning and development from a variety of perspectives, including those from the public and private sectors.



Taking a fresh look

The key questions

The health care labour market in London is substantially different from that in the rest of the UK. These differences are often seen as disadvantages, but over the course of the first workshop, participants challenged this view with questions such as:

- In some cases, high turnover may be what keeps the system buoyant and energised, so why is it only seen as problematic?
- Can we have a workforce that is stable in numbers, but that allows people to pass through?
- At what level do vacancies become a significant issue?
- Why do we see high levels of temporary staff only as a problem?
- What is the correct staffing establishment, and who decides this?
- How do we define what 'the work' is, and who do we need to do it?
- Why are we wasting energy on trying to constrain a system that is inherently mobile?
- How can we make strengths of London's apparent weaknesses, which centre on wastage and the export of highly trained staff?

During the second workshop participants were more concerned with the following questions:

- How can the NHS be marketed as an attractive employer, and what can the NHS learn (rather than just transplant) from other sectors? Why is it that organisations such as Penguin Books are so successful at attracting potential recruits – what are the messages that would attract people to the NHS?
- What is meant when employers talk about being 'more flexible'? Is this concept fully understood and exploited, or is the NHS too cautious and risk-averse an employer to allow employees more autonomy over their working conditions and their roles? To what extent are jobs truly matched to people's needs?
- How can human resources within the NHS be developed and supported to be more imaginative in the design and management of the workforce?
- How can workforce issues be given more priority within the NHS? How can they be made central to corporate thinking and not just an add-on?

The key themes

The following key themes emerged from the workshops, and pointed to possible areas for policy intervention:

- managing 'churn'
- ensuring coherence in planning
- keeping in touch with former staff
- encouraging innovative employment practices

- marketing the London lifestyle
- highlighting training opportunities in London
- encouraging an inclusive approach to NHS employment.

These themes are discussed in more detail below.

Managing 'churn'

The NHS workforce in London is characterised by 'churn' – rapid turnover, high rates of wastage and vacancies and considerable use of temporary staff – but we should work with this, rather than trying to fight it. If we could improve our understanding of the factors that determine the comings and goings of the London workforce and the routes in and out of the health care labour market – that is, the 'churn paths', we could better manage this process.

Ensuring coherence in planning

The London health care labour market is very fragmented, with competition between different employers. London health care is not recognised as a 'system', and partnerships are not rewarded. Ensuring coherence in planning or collective working between employers remains a key challenge. Networks of information and systems of action for tracking and assisting rapid mobility – not only in and out of London, but also around and within London – could be important steps to overcoming this fragmentation. More information is needed on:

- what pulls people into London in the first place
- what defines a 'good' place to work, even in the challenging London health care labour market
- where in London staff do not want to work, and why
- why staff leave.

We also need to determine who has, or should have, this knowledge, how it can be accessed, and how it should be fed back to individual organisations to close the information loop.

Keeping in touch with former staff

National policy focuses on getting people to return to practice, but potential returners need to be kept informed and interested while they are away and, specifically, they need to be kept connected to London-based practice. Competition between trusts in London is unhelpful, and more collective, co-ordinated action is required. Ideas emerging around this theme include:

- the need for exit interviews to discover why staff are leaving
- more evaluation of the experience of new recruits to discover more about what they think after six months in post
- the need to facilitate the two-way movement of staff between trusts, organisations and sectors through exchange schemes, sabbaticals and rotations
- 'gap' years that allow people to take time out and to return to their job without feelings of guilt. This could link to systems of reciprocity with other areas or countries
- a focus on managed career development, keeping people in touch and up to date as a pan-London activity
- 'cafeteria benefits' – a menu of staff benefits that allow individual staff to custom design their career and work journey.

Encouraging innovative employment practices

Local examples of innovative HR practice are described in the next section of this policy paper. Many of them are not yet embedded in the NHS, despite being regarded as good employment practice in other sectors.

Generally, the NHS is seen as cautious, risk-averse and innately conservative in its management of its workforce. In order to become more creative, it needs to encourage an environment of challenge accompanied by high levels of support and development.

Marketing the London lifestyle

Although living and working in London is often viewed as a negative experience, it can also be marketed as the gateway to an exciting life in a dynamic city. London has some of the best health care training and careers in the world. If some of the negative aspects of London life could be more effectively addressed (notably housing), the capital's labour market can achieve a competitive edge by exploiting its career network, while offering a flexible approach to jobs and skill development. Many people are drawn to London in the first instance, rather than to the UK or the NHS. This means recognising and taking into account the needs of transient workers employed in London.

Highlighting training opportunities in London

London has the size and scope to offer the whole range of health care careers plus many alternatives. It should 'sell' the prospect of transferable skills to potential entrants, both within and outside health care. For example, the NHS could offer modules of specific learning related to GCSE and A-levels, university work experience or a qualification in catering. This 'normalises' the NHS as an employer, giving the message that you don't need to join for life or go into a structured career path. In effect, working in the NHS in London could give new skills to anyone. This links with the idea of joint appointments, exchange schemes, taster packages of life in the NHS and sponsored placements with industry, the private sector, the City, and so on.

Encouraging an inclusive approach to NHS employment

London's population is currently 7 million and is set to grow even further, which means that its workforce will become more diverse, more international and more temporary. We need to consider the likely make-up of the health sector workforce in 15 to 20 years' time and target potential candidates now. They include the following groups:

- the 20–30 year olds who are passing through London on their way to other world destinations
- local communities of black and minority ethnic populations
- refugees and asylum seekers who may enter this country with professional qualifications
- older people.

The challenge is to make the NHS in London an attractive and supportive place for people in these groups to work.

Practical examples

In this section of the policy paper, we give eight examples of how NHS organisations are meeting the key challenges in London. Each example illustrates the theme that runs through this policy paper – that the dynamics of the London health care workforce must be creatively managed, and these approaches may be different to those used elsewhere in England. Where possible, we have reported on evaluations of these interventions, however some are at an early stage and others may only be appropriate within specific circumstances. We are providing these case studies as examples, rather than suggesting that all may have a widespread application.

Widening access to medical school

The challenge

The Guy's, King's and St Thomas's School of Medicine (GKT) wished to attract more students from the local community who were from working class and under-represented ethnic minority backgrounds. The school recognised that entry to traditional medical courses required levels of academic achievement unlikely to be attained by most students from these backgrounds.

The solution

In 1998–99, the Higher Education Funding Council for England (HEFCE) invited medical schools to apply for additional funded student places under the Department for Education and Skills' (DfES) Widening Participation initiative. GKT decided to use this opportunity to ring-fence places for local students from socially and educationally disadvantaged backgrounds. It developed an Access to Medicine project, consisting of an extensive Outreach Programme (largely funded by the Pool of London Partnership through Single Regeneration Budget Round Six) and an Extended Medical Degree Programme (EMDP).

Rather than widening participation by lowering the entry requirements to the conventional five-year Bachelor of Medicine and Surgery (MB BS) course, GKT sought to attract students who had the potential to learn to become good doctors, but could not offer the necessary academic grades. Selected students are admitted to the EMDP. They train alongside other medical students, but complete the first two years of medical school training over three years. This allows EMDP students to study at a more appropriate pace and with better support. They therefore take six years to complete their training, rather than the standard five years.

GKT works with local schools and colleges to encourage students to apply. To be eligible, students must be nominated by their school, their projected A-level results must be lower than those of students admitted to the conventional course, and they must live or study in one of the ten inner London boroughs covered by the programme.

Selection is based largely on performance at a semi-structured interview, but note is also taken of a report from the student's school (in addition to the report in the University and College Admissions Service form) and their scores on a 'Personal Qualities Assessment' test.

GKT runs a wide range of outreach activities in conjunction with local schools and colleges to help raise the educational and career aspirations of the students, and to prepare them academically and culturally for life at medical school. These include:

- career events
- work experience
- mentoring for sixth formers considering a career in medicine
- an after-school 'Science in Action' lecture series for A/AS level students to encourage their interest in science.

The project has worked with over 1,800 secondary school students since January 2002.

The impact

Nine students entered the EMDP in 2001, its first year. Twenty students entered in 2002, and 24 placement offers have been made for the September 2003 intake. The majority of students are from minority ethnic communities, and most come from families with little or no experience of higher education.

An evaluation of the programme at the end of 2001 reported that all nine students enrolled in the 2001 intake had successfully completed their first year (Applejuice Consultants 2002). It found that the programme was helping to increase the young people's awareness and aspirations concerning higher education and employment.

The GKT Access to Medicine project shows that initiatives to widen participation are both labour intensive and resource intensive. Raising aspirations and attainment among young people from socially disadvantaged communities is a long-term project. In order to succeed, these initiatives require secure long-term funding.

Employing staff from abroad

The challenge

University College London Hospitals (UCLH), like all inner-London teaching hospitals, has to devote considerable effort to recruitment in order to replace employees who move on to other jobs after enhancing their careers in a teaching-hospital environment.

International recruitment is widely used by the NHS in England. The challenge for NHS organisations is to achieve a balance between being efficient in terms of the methods used and being ethical – that is, the approach supports the individuals who are recruited and does not have a negative impact on the 'source' country.

The solution

Working with a specialist recruitment agency, UCLH have on four occasions successfully recruited nursing staff from the Philippines. The agency is on the 'preferred provider' list of recruitment agencies published by the Department of Health, and the Philippines is one of the countries mentioned in the Department of Health Code of Practice on International Recruitment as an acceptable source of nurses (Department of Health 2001b).

UCLH staff work with the agency to interview and recruit nurses in the Philippines. The nurses work full time, initially on two-year contracts, and are employed on standard terms and conditions of employment.

The trust offers the nurses accommodation and a 'welcome pack', and helps them to integrate into the London community – for example, by opening a bank account for them. There is also a 'buddy' system whereby Filipino nurses already working at the trust offer support to recent arrivals.

All international recruits go through a structured orientation and assessment programme, covering both teaching and practice. Staff at the trust are given training if they are to be mentoring the international nurses.

The impact

The trust reports a very high retention of the nurses it has recruited from overseas. On the last recruitment trip, 73 nurses were offered jobs, 68 actually travelled to the UK, and all are still working at the trust. The trust is now planning to recruit internationally for radiographers. In recognition of its good practice in international recruitment, UCLH recently received an award from the Philippine Government.

Co-ordinating the approach to recruitment

The challenge

The Hammersmith Hospitals NHS Trust has to make major recruitment efforts to maintain its staffing levels. Despite a recent fall in vacancies, the trust still needs to recruit several hundred nurses each year.

In the past, recruitment at the trust was localised and unco-ordinated, with managers undertaking their own recruitment. This was essentially a reactive process, based primarily on advertisements in professional journals. There was often a long turnaround time between applicants responding to vacancies and being invited to interview, and some applicants found other jobs in the meantime.

The solution

The trust centralised the recruitment process, using a strategic approach to determine targets. It developed a yearly recruitment plan, based on an analysis of vacancies and forecasts of staffing needs. This enabled targets to be set for different occupations and departments within the trust. The centralised recruitment department developed a range of new approaches. These included:

- commissioning an advertising agency to develop a distinctive brand for the trust (including the slogan 'We are the best place to nurse in London')
- using a range of media for advertising: for example, bus posters and radio
- targeted recruitment in major cities throughout the UK, involving local advertisements and open days in local hotels
- improved technology to streamline the recruitment process – the introduction of customised computer software led to a 70 per cent reduction in the 'paper trail'
- a recruitment website – trust managers can now post vacancies directly on to the site as soon as they occur.

The centralised recruitment department has staff from 11 nationalities and aged 19–55. A nurse works as part of the recruitment team, nurse applicants can speak to her, and she will then arrange an interview as soon as possible to activate the application.

The trust runs 'return to practice' schemes for nurses and radiographers. It also offers flexible working, on-site accommodation for 'difficult to recruit' staff and an on-site nursery, and is investigating the introduction of a school holiday club. There is a strong emphasis on offering further training and development to staff.

The impact

Vacancy rates have declined from about 24 per cent to 9 per cent in recent years. With the use of web-based recruitment, the trust has been able to reduce its overseas recruitment in favour of less costly local and national campaigns.

Providing clinical experience for refugee doctors

The challenge

Refugee doctors who have passed the relevant English language and clinical tests often find it difficult to compete with UK-trained doctors for senior house officer (SHO) and GP registrar posts, as well as for places on the general practice vocational training scheme (GPVTS). The London Deanery recognised a need to help refugee doctors prepare CVs, develop interview skills, improve their language skills for consultations, and understand general practice and hospital medicine in the UK.

The solution

In 2001, the London Deanery secured funding to organise clinical attachments for refugee doctors at hospital trusts in London. Almost 30 refugee doctors took part in the scheme (Phase 1). In 2002, the GP department of the London Deanery won further funding to develop a similar scheme of clinical attachments in primary care (Phase 2). As there was no further funding to continue the project in acute trusts, Phase 2 was redesigned to accommodate attachments in both primary and secondary care.

Working with primary care, various hospital trusts, providers of the International English Language Testing System (IELTS) and Professional Linguistics Advisory Board (PLAB) groups, the Workforce Development Confederations in London, and various refugee organisations, the London Deanery developed a 12-week placement scheme for refugee doctors in London – the Refugee Doctor Clinical Experience Scheme.

Under the scheme, doctors spend six weeks in a hospital placement and six weeks in primary care, working with consultant and GP tutors. During the hospital attachment, doctors receive training in basic IT skills through Chase Postgraduate Medical Centre. During the half-day release course running for the entire 12 weeks of the programme, the refugee doctors improve their communication and language skills through role play and by analysing videoed consultations to help them recognise and understand colloquial language and mannerisms. They also practise interview skills and CV writing and take part in a self-directed learning group to continue their professional development.

A steering group with representatives from the London Deanery, WDCs, and IELTS providers, interview and train the refugee doctor tutors, interview refugee doctors, and through the WDCs match the doctors with an appropriate placement. The Refugee Education and Training Advisory Service (RETAS) agreed to fund travel expenses and child care for the refugee doctors during their placement.

To be eligible for the scheme, refugee doctors must live in the London area, have passed the PLAB 1 exam and preferably be ready to take PLAB 2. The Steering Group has limited the eligibility to a smaller group in order to target those refugee doctors who are ready or almost ready to start a SHO post.

The impact

Following Phase 1 of the clinical attachment scheme in acute trusts, 17 of the 29 doctors are now in substantive SHO posts.

Phase 2 of the scheme was advertised through the BMA database of refugee doctors, through the PLAB groups and refugee organisations. Of 17 eligible applications, 12 doctors were offered places and began their attachments in April 2003.

From August 2003, two Vocational Training Scheme (VTS) three-year rotations for three refugee doctors will begin at Chase Farm and Homerton Hospitals.

Implementing job rotation for nurses

The challenge

High staff turnover, excessive use of temporary staff and poor continuity of care in certain 'hard-to-staff' mental health services in central and west London.

The solution

Brent, Kensington and Chelsea and Westminster Mental Health Trust and Ealing, Hammersmith and Fulham Mental Health trusts (now Central and North West London and West London Mental Health NHS Trusts) set up a joint initiative in February 1999 to attract nurses to hard-to-staff areas – adult in-patient acute services, elderly continuing care and community rehabilitation – and to support and develop nurses already working in these areas. The scheme aims to improve the recruitment, retention and motivation of nursing staff by providing a structured job rotation scheme, linked to work-based learning education.

The objectives were to provide service users with better continuity and quality of care because the trusts would be able to:

- staff the mental health units and remain within budget
- replace bank or agency nurses with nurses who will become part of the care team
- give service users and carers better continuity of care, provided by nurses they recognise as regular members of the care team and with whom they can form longer-term relationships
- invest in junior staff with a view to encouraging them to take up a long-term professional career in health care
- evaluate the scheme within an action research framework.

A joint trust committee of directors of nursing, senior managers and HR personnel designed the rotation scheme and consulted local managers and staff in hard-to-staff areas. In its final form, with support and investment from the education consortium in west London, the scheme was launched in 2000. Its main component is a staff-development programme offering nurses three eight-month staff nurse placements in a variety of service areas: acute adult mental health, older adult assessment, rehabilitation, eating disorders, psychiatric intensive care and community mental health.

The two-year rotation scheme includes a part-time modular degree course provided by the school of health at Middlesex University. The six work-based learning modules focus the nurses on developing their practice in care co-ordination, in contemporary interventions in mental health care and in small-team management. A staff member in each of the service areas provides professional nursing supervision for each nurse.

The primary aim is to help novice nurses become competent practitioners, and in so doing, to improve recruitment and retention and to promote a culture of life-long learning. The first cohort of 24 participants (12 at BKCW and 12 at EHF) began on the rotation scheme in February 2000.

The impact

A recruitment drive attracted 25 nurses to the scheme. An interim evaluation suggested that 11 of these nurses were new to the trusts and would not have considered working for them without the scheme. As a result, 18 service delivery areas were able to replace some agency and bank staff with a regular staff nurse. The scheme also appears to have widened the recruitment pool; just under half (45 per cent) of the nurses recruited from outside the trusts reported that they had not considered working at either trust before hearing of the scheme.

The evaluation noted that participants were very satisfied with the educational component, three-quarters describing it as either 'good' or 'very good'. The scheme has secured financing for a second and third group of nurses, and has proved to be an attractive local solution to nursing staff shortages for managers, nursing staff, regional workforce development forum, workforce planners, clinical effectiveness managers and university partners.

In 2002, 82 nurses had joined four cohorts of recruits in four separate development areas across the two trusts. A substantial number have completed the two-year scheme with the trusts and continue to work with them. A spin-off project – an Experienced Nurse Rotation Scheme for a cohort of 10 experienced trust staff – was also funded, and is currently under evaluation. The purpose of this scheme is to enable experienced nurses who want to remain with the NHS and the local NHS trust to rotate their job, to gain accreditation for their learning and to complete work-based education to support their job rotation and career intentions. A number of other trusts are developing rotation schemes and have been influenced by the research work.

Using creative solutions for retention

The challenge

Like many other trusts, the East London and the City Mental Health Trust has difficulties retaining staff. The trust also wants to reduce its sickness absence rate from its current 4.5 per cent.

The solutions

Rather than seeking a single measure to address these problems, HR director David Cooper decided to introduce a series of smaller interventions in the hope that they would have a cumulative effect on staff. The interventions aim to help staff feel valued in the organisation, and three are outlined here:

Discretionary points. After the discretionary points scheme for nurses and allied health professionals (AHPs) was introduced across the NHS, the trust calculated that around 90 senior nurses and AHPs were eligible. However, only nine staff applied in the first two years. The trust put this down to the application process, which required staff to provide a portfolio of evidence to justify their claim. As an 'act of goodwill', and following agreement with the trade unions, the trust decided the following year to award all eligible staff one discretionary point (worth around £270). If staff wanted further points, they would have to go through the application process. The feedback from the trade unions and staff was excellent. The trust is now rolling the scheme out for the third year.

Rewards for perfect or near perfect attendance records. The annual staff-attitude survey found that many employees were unhappy about not receiving recognition for the fact that they had taken no sick leave. Borrowing an idea from the private sector, from 1 April 2003 the trust introduced a scheme to recognise staff with a perfect or near-perfect attendance record. At the end of the year, employees who have taken no sickness leave will be entitled either to two extra days' annual leave or to a monetary reward of £50 a day for two days, or a combination of the two. Employees who have taken only one day of sickness leave will be entitled to one day's annual leave or £50.

Day off for moving house. The trust also decided to offer a day's paid leave to staff who were moving house, in recognition of the stress involved. Fears that this offer might be abused by 'serial house-movers' proved unfounded and employees have reacted enthusiastically.

The impact

The trust has not formally evaluated any of these initiatives, but has received much positive feedback from staff and unions. Staff attitude surveys have shown year on year improvements and the staff turnover rate dropped from 18.8 per cent in September 2001 to 15.7 per cent in December 2002.

Stabilising the workforce

The challenge

In 2001, St Mary's Hospital, Paddington, spent more than £12 million on temporary nursing and midwifery staff. The vacancy rate was 26 per cent – equivalent to about 300 full-time registered nurse and midwife posts – and the turnover was 34 per cent. The trust was only managing to fill 50–60 per cent of its vacancies with temporary staff.

The solution

In 2000, the director of nursing began a review of nursing and midwifery staffing. This involved one-to-one meetings with each ward or department sister and their senior nurse, a total of 48 clinical areas. Each ward sister was asked to provide three months of off-duty rosters, details of staff sickness and absence and an estimate of the safe levels of staff needed to provide a service, and was invited to raise any other issues they wished.

The review focused on the number and grades of employees needed on each shift to provide the minimum staffing level, as well as on the management of the ward or department, the standards of patient care and the amount of time spent undertaking non-nursing duties. This approach relied on the professional judgement of the senior nurses involved, based on their practical experience in their area of service provision. The director of nursing and the deputy and associate nurses corroborated the evidence and visited clinical areas.

They found that there was little information on the use of temporary staff, except in the form of gross costs for the whole hospital. All posts had been funded at 0.96 whole-time equivalent (WTE), which led to a staff shortfall at ward level or an overspend, as ward sisters were unaware of how their establishments had been funded. The final analysis was discussed fully with the ward or department sister and their senior nurse, and an establishment was agreed that would provide a minimum but safe service to patients.

The results showed that overall, the establishment was at least 70 WTE registered nurses and midwives short of providing a minimum staffing level. An estimated £1.5 million was needed to remedy this. The findings of this review formed part of the financial negotiations with the health authority.

A business case was presented to the health authority, proposing to reduce vacancies by undertaking an international recruitment campaign. It was envisaged that over a three-year period, this would stabilise the workforce and make savings of £1.3 million on employing agency nurses.

Management also developed the hospital's staff bank. The strategy was to match the rate of take-home pay for a bank member and encourage agency staff to join the bank. Gradually, embargoes on the use of agency staff were introduced, so that ward or departmental staff would take the initiative and start to recruit their preferred agency staff to the hospital staff bank.

The trust board agreed to support the proposed approach to stabilising the nursing and midwifery workforce, and it was ranked among the top three strategic priorities of the trust's business plan. An international recruitment programme was initiated, with recruitment from Italy, Spain, the Philippines, New Zealand and Australia.

The impact

Patient care has improved significantly over the past two years. The incidence of pressure ulcers was reduced, from 8.33 per cent in July 2001 to 6 per cent in July 2002. For the whole trust, formal complaints by patients – totalling about 195 in 2000 – have fallen by one-third.

Today, the trust has a vacancy rate of 11.5 per cent – less than half the rate two years ago. Turnover has fallen to 20 per cent, and the fill rate by temporary staff is 90–95 per cent. There is now a 60:40 bank to agency ratio, compared with 15:85 in 2000.

There is a waiting list of nurses who wish to work on the paediatric intensive care unit. It has moved from a one-star rating in 2001 to three stars in 2002.

Training rotation for junior pharmacists

The challenge

Health service providers in south east London had severe problems in recruiting and retaining junior pharmacists. Turnover rates were 60 per cent – most pharmacists in the area only stayed in post for an average of 1.7 years – and vacancy rates were around 20 per cent.

The solution

A research project commissioned by the former South East London Education Consortium (SELEC) in the late 1990s found that the poor recruitment of pharmacists was caused by a scarcity of graduates combined with the pressure to fill more posts to meet the growing demand for services. The reasons for the poor retention included low job satisfaction, inadequate support and the lack of a career structure. The project report recommended that NHS pharmacy organisations should work together to develop a 'cross-sector rotational training programme' for junior pharmacists.

SELEC and its successor, the South East London Workforce Development Confederation (SELWDC), funded a project manager (later project director) to oversee the development of this programme. The Structured Training and Experience for Pharmacists (STEP) programme was devised to provide junior pharmacists with up to three years of competence based training and education.

Under the STEP programme, junior pharmacists undergo a period of 'foundation training' for 18 months at one of four acute hospitals in the area. These hospitals hold the pharmacists' contracts of employment when they are rotated to other trusts for up to three speciality placements. These placements can be at any of the 15 trusts in south east London, including acute, primary and community care and mental health. The pharmacists are mentored and offered opportunities for postgraduate education.

Junior pharmacists are moved from grade B to grade C at the end of the foundation 18 months, provided they have attained a Certificate in Pharmacy Practice and have met all required competencies.

The impact

The first 22 pharmacists joined STEP in September 2000, and by September 2002 there were 60 pharmacists on the programme. Turnover of junior pharmacists in South East London has fallen from 60 per cent to 17 per cent and their average length of stay has risen from 1.7 years to 1.85 years.

The success of STEP has had another positive outcome, closer collaboration between the 15 separate NHS organisations in the area. The trusts feel that the overall benefits to the local health economy outweigh any difficulties that have arisen within individual trusts.

Conclusions

The challenging characteristics that make London's health care labour market distinct and sometimes different from those in the rest of the NHS need to be acknowledged and managed effectively. This will require the adaptation of national initiatives to meet workforce challenges, as well as 'home-grown' London responses.

Those responsible for recruiting, retaining and motivating the health care workforce in London are faced with a double challenge. First, they have to interpret and implement national HR policy (and meet national NHS targets). Second, they must also ensure that their interventions are appropriate to the unique context of the London labour market and sensitive to the needs of delivering patient care. The examples described in the preceding part of this policy paper show that it is possible to achieve this balance. The critical success factors are the need:

- to undertake a proper situation analysis that takes account of the distinctiveness of London
- to make context-specific interventions
- to sustain an integrated approach to managing these interventions.

The impact of national policy initiatives

'Top-down' solutions to national NHS workforce challenges may not always work effectively in London. As far as possible, within a national NHS framework, the health sector in the capital must be supported to find its own solutions to its own unique challenges.

Policies designed to solve the problems in London need to be assessed in the context of national NHS policy, and vice versa. Several current national initiatives could create additional tensions in London. The NHS has been through a series of 'top-down' reforms and restructurings over the past 20 years. Continual restructuring can undermine the sustainability of workforce solutions and damage staff morale. The likely impact on London of new national initiatives must also be assessed, and their implementation managed in a manner sensitive to the capital's labour market. These initiatives include:

The merging of workforce development confederations (WDCs) with strategic health authorities (SHAs). WDCs were relatively new organisations, introduced to strengthen the planning and development of regional workforces. This vital function will have to be maintained in the newly merged organisations.

Reorganisation of NHS primary care trusts (PCTs). PCTs are new bodies designed to improve the co-ordination and local delivery of primary care. As they mature as organisations, they will impact on the profile and management of the primary health care workforce, in London and elsewhere.

Foundation hospitals. It is too early to say whether the creation of 'foundation hospitals' could lead to more fragmentation than coherence in delivery of care and in staffing policies. However, their impact will need to be monitored, at a time when efforts are also being made to encourage trusts to work together to introduce flexibility into the London system.

NHS pay. The long-awaited Agenda for Change reform of NHS pay (Department of Health 1999) could bring about improvements in London, or it could act as a constraint. This depends on how the new initiative deals with the London labour market, and how it is implemented over the next few years.

- **Capitation charges.** Weighted capitation funding for education and training, especially in relation to the individual budgets of London WDCs, could undermine joint working to develop a much needed pan-London approach to workforce challenges.

- **Performance targets.** Setting targets for workforce numbers could lead to focussing on a 'numbers game' rather than the development of new roles for workers. Comparing the targets for London with those for the rest of the NHS is problematic. In London, in particular, turnover and vacancies need to be energetically managed, rather than passively monitored. The mobility and flexibility of staff needs to be supported, and temporary staff have to be managed as a strategic, flexible solution rather than a reactive, stop-gap measure.

The interlinked issues identified and discussed in this policy paper highlight the complexity of the policy and practical challenges facing those responsible for workforce policy, planning, management and development in London. Together, they highlight some of the main dynamics that make the labour market in the capital distinct and different from the rest of the NHS. These dynamics cannot be prevented, but they can be more effectively managed in a way that will improve the delivery of health care in the capital.

There are already examples of positive local actions to address London's workforce challenges. These show it is possible to achieve a balance between national HR policy and local action that takes account of the unique context of the capital's labour market. National HR policies and initiatives may not always work effectively in London but, equally, London cannot, and should not, function in isolation from the rest of the NHS. The overall message from this policy paper, and the theme that underpins its recommendations, is that national and local HR policies must be aligned with the dynamics of the London labour market if they are to be successfully implemented and sustained.

Recommendations

The recommendations outlined below are based partly on analysis and partly on the outcomes of the workshops described earlier in this policy paper. They present guidance on the framework of issues that workforce planners, policy makers and managers need to consider in order to develop the NHS workforce in a way that takes account of the dynamics of the London health care labour market. They are not overly prescriptive as their applicability and appropriateness must be assessed in the local context.

The first recommendation focuses on improving the London wide health labour market analysis and workforce planning capacity. Workforce development confederations (WDCs) and strategic health authorities (SHAs) have a key role to play on this issue, collaborating with other planning agencies to ensure that the implications of London's growth and regeneration for health and for health labour markets are properly assessed.

Develop networks, information and systems for action

London must have an effective, city-wide planning and information base for its health care workforce. The five London based WDCs have been following a more integrated approach to assessing the workforce needs of the capital, bringing together employers and the education sector. This co-ordinated working requires further support, as the WDCs merge with SHAs. The quality of information about the London health care workforce also needs to be improved, particularly that relating to GPs and primary care staff, especially given the growing emphasis on developing local community health services. Data should be shared between employers.

The current resourcing of these functions in the NHS in London does not permit effective workforce planning; there must be further investment in developing the HR planning capacity, in terms of both technical skills and change management capabilities. The modelling of workforce scenarios, based on realistic assumptions, and accurate data on the workforce are also required, so that the likely impact of population growth and changes in service configuration on workforce requirements in London can be assessed.

The five recommendations that follow are interlinked, and focus primarily on employment policy and practice. As such, they will have a particular resonance for the HR functions in health care organisations in London. However, the recommendations are made from the perspective that the HR challenges are so intense that they require system wide responses. The HR function will often play a lead role in determining and applying local solutions, but these interventions will only be fully effective when applied within an organisation wide approach to workforce issues. These are HR challenges, but they are challenges for more than just the HR function.

Design for transience

We should manage the relatively high turnover of the health care workforce in London, rather than try to fight it. This means using temporary staff more effectively; encouraging job growth rather than forcing staff to move to develop their careers; and supporting career structures and rotation schemes that exploit this high turnover in a way that meets staff needs while minimising the negative impact of job changes. It also means that any national NHS targets for staff turnover need to be re-assessed for their appropriateness to the London context.

Keep staff who have left connected to employers and the NHS in London

Employers have to recognise that career breaks, sabbaticals and study leave are part of the normal career aspirations for many health care workers, rather than a 'problem' to be managed or a sign of disloyalty. National NHS policy focuses on getting people to return to practice, but potential returners need to be kept informed and interested while they are away, and specifically they need to be kept connected to London-based practice. Flexible employment practices and pension schemes have to be introduced to support workers through and beyond breaks in their employment, and keep them connected to the NHS for as long as they wish.

Develop a more effective and adventurous approach to attracting and keeping staff within the NHS

This policy paper has described local examples of 'innovative' HR practice, showing that it is possible to find effective local solutions, even in the challenging London labour market. Some of these solutions are not yet widespread in the NHS. Innovation and local initiative have to be encouraged. We need to identify the organisations that exemplify good HR practice in London health care – and beyond, where relevant – and to analyse in more detail 'what works' and how, as well as overcoming organisational barriers to innovation. Wider use of these good practice findings need to be supported. There is also a need to review national HR targets, policies and initiatives, to ensure that they encourage innovation and good practice rather than curtail it.

Exploit the appeal of London

London is one of the most exciting, dynamic and culturally diverse cities in the world. There should be co-ordinated marketing and 'branding' of the NHS in London, to emphasise the attractions of living in the city, as well as to help create a more positive image of the variety of careers in health care. Although living and working in London is often viewed as a negative experience, it can also be marketed as the gateway to an exciting life in a dynamic city.

London has some of the best health care training and careers in the world. It has the size and scope to offer the whole range of health care careers plus many alternatives. It offers economies of scale not available to any other health region in the UK, and can offer an exciting range of pre- and post-basic training opportunities. Part of the 'branding' of London should be to publicise these unrivalled opportunities.

Involve the total population in the NHS workforce

London must invest more resources and effort in 'growing its own' health care workforce. It will always rely to some extent on attracting new workers from elsewhere in the UK and abroad, but it must improve access 'from its own back yard', on the grounds of both efficiency and equality. This means removing the current barriers – real or perceived – to health care employment, creating new entry points appropriate for London's local populations – for example, through regeneration programmes, and including refugee and asylum seekers. This in turn will require health care employers, working with the WDCs and SHAs, to develop a better understanding of the capital's local labour markets.

Many of the health workers and managers involved in the initiatives described in the preceding part of this policy paper noted that what they are doing is neither unique nor particularly complex – it is just good employment practice. However, they clearly have an understanding of how the labour market for London health care works. Those involved in the policy, planning, management and development of the London NHS workforce must ensure that these initiatives, and others like them, become the norm rather than the highlighted exception.

Ways ahead

If the Government's plans for a modern, flexible and well-staffed NHS are to be realised, we will need new approaches to workforce planning. Well-informed, tactical responses to local constraints and opportunities must combine with far-sighted and co-ordinated national human resource strategies in key areas such as flexible working and retirement.

While this policy paper is focused on finding particular strategies and ways ahead for London, we hope that its approach will have wider relevance for NHS staff and policy makers responsible for human resource management and development beyond the capital.

The King's Fund will continue to contribute to wider debate and capacity building across the health care workforce in London and beyond. Over the coming months, our workforce programme will take forward a range of research, policy and development activities, including:

London partnerships. Working in partnership across sectors will be crucial if we are to meet Londoners' current health care demands effectively, and expansion and improvement in the future is to be achieved. The King's Fund will continue to work with London's workforce development confederations, strategic health authorities and network of NHS human resource managers (SHRINE), to explore new ways of ensuring a flexible, high-calibre health care workforce for London.

Research and policy analysis. There is a need for more independent analysis of the workforce implications of wider government policies. We will continue to develop our contribution in this area in the short term, by analysing the impact of the introduction of foundation trusts and the implementation of the new pay framework for NHS staff, Agenda for Change, on London's health care workforce.

International recruitment. We will deepen our analysis of the role of international recruitment in the London health care workforce, by identifying a cohort of nurses recruited from abroad and now working in London, and studying patterns over time, such as duration of stay and how many return home, as well as looking at aspects such as impacts on health care capacity in their countries of origin.

Care services in London. Our November 2002 web paper *Unfinished Business: Is a crisis in care still looming?* argued that care services for older and disabled people face a major staffing crisis unless a long-term financial settlement for social services is secured. In 2003/04, the King's Fund will take forward a major investigation into how local authorities – and health and housing professionals – are managing care services for vulnerable older people in the face of serious shortages in London.

Recruitment and retention of older staff. Discussions are underway with a range of partners about piloting specific recommendations in our 2002 research paper *Great to be Grey: How can the NHS recruit and retain more older staff?*, such as targeted recruitment strategies and flexible working in selected sites around London.

Employment for health. Work on the links between health, environment and social issues will continue to be a priority. We are supporting the London Health Commission, a cross-cutting strategic body set up to act as a catalyst, monitor key indicators and drive health improvements in London, in a new initiative to promote employment across London as a health measure.

Health advocacy. We will continue our work to develop and support local health advocates in some of London's most deprived areas, as a bridge between health care professionals and local communities' needs, and as a route into NHS-related employment. We are developing accredited training for health advocates from ethnic minority communities.

Community-based initiatives. Our £1.27 million grants programme supports a wide range of practical initiatives to promote health and wellbeing in London, through a combination of capacity building and resources. For example, we are helping improve London's hospital environments through projects designed and managed by nurse-led teams. We work with community-based leaders taking forward innovative local health improvement projects.

Health care leadership. The King's Fund runs a wide range of courses to help managers and health professionals develop their leadership skills, supporting specific groups, such as refugee doctors. Increasingly, we are expanding these programmes to other sectors, with the aim of building local strategic partnerships to take change forward.

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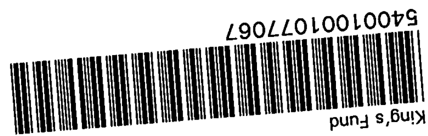
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The NHS in London faces many challenges. It must provide effective health care in a city where the population is expected to rise by 700,000 by 2016. It has to serve many diverse communities – each with their own health care needs – and tackle major health inequalities between those communities.

Yet the capital faces a number of challenges to grow, retain and deploy its health care workforce. Determined action is needed if London's NHS is to employ and manage effectively the trained and motivated workforce it needs to meet the needs of the population.

In Capital Health? examines ten key challenges facing the NHS in London. The capital's health care workforce is mobile, characterised by high rates of staff turnover and high levels of vacancies. There are also difficulties recruiting and retaining new and experienced staff, partly because of the high cost of living in London.

This policy paper illustrates how London is responding to these challenges, using a range of case studies. Solutions include: encouraging local applicants and students from non-traditional backgrounds to become health professionals; co-ordinating recruitment activity; and providing flexible rotation schemes for experienced staff.

Top-down solutions and national HR initiatives may not always be appropriate or fully effective in the distinctive London health care labour market. In such cases, the capital needs to be encouraged and supported to find its own solutions.

The paper concludes with a set of recommendations that encourage the NHS in London to:

- develop networks, information and systems for action
- develop a more effective and adventurous approach to attracting and keeping staff within the NHS
- exploit the appeal of London as a place to work and live.

In Capital Health? will be invaluable reading for staff and managers, planners and policy-makers in the NHS, educational institutions, trade unions and professional associations.

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