Nursing numbers in Britain: the argument for workforce planning

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When the Labour government in Britain took office in 1997 it inherited a growing problem of nursing shortages, which finally hit the headlines in 1998. The shortages have been recurring ever since, particularly during the influenza "crisis" last winter. How has the government fared in dealing with nursing shortages, and has it put the worst behind it?

Summary points

- Britain has a serious shortage of nurses, as well as problems in recruiting and retaining them
- It is not simply that there are too few nurses; some key skills shortages also exist, with increasing demand for more qualified staff in some areas
- Much better planning of the workforce is required, and this needs to be more integrated with the planning for other groups in health care
- A change in the pay system may help, but the creation of better work environments may be part of the solution
- The rapid pace of change in the nursing profession has produced a challenge that the NHS needs to address

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Roots of the problem

The roots of the recent nursing shortages lie in the early 1990s. As part of the NHS reforms and the introduction of the internal market, there was a move towards an employer led system to determine intakes to nurse training. The involvement of NHS trusts was to be welcomed, but the narrow focus, varying capacity of local training and education consortiums, and lack of a national overview meant that most trusts underestimated required staffing numbers. The system also underestimated non-NHS demand for nurses, particularly in the rapidly expanding nursing home sector. The effect of this new "planning" system was to reduce markedly the number of student nurses. In 1984 England had more than 75 000 nursing students and pupil nurses. By 1994 that number had more than halved. The register of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting showed its largest annual decline in the number of practitioners in 1998 as a result of the reduction in trainees and failures to re-register. Although the number for 1999 has risen, it is still 6000 lower than the 1990 figure of 19 000.

Because of reductions in the number of nurses staying in Britain to work, international recruitment has increased markedly. Nearly 5000 new nurse entrants from overseas joined the central council's register in 1998-9—that is, 28% of the total registration.[1] The Department of Health has since issued guidance to NHS trusts to advise them not to over-recruit and damage nursing labour markets in developing countries.[2] Increased use of agency staff has been another solution, particularly in the south east of England, but this may damage the care process and add unacceptable costs. Problems of supply have been exacerbated by increases in job turnover, as more nurses have taken jobs in the growing private sector. This has taken place against a background of increasing workload. From 1990 to 1998 all acute activity, as measured by "finished consultant episodes," rose by 38%, from 6 936 000 to 9 549 000. The number of emergency admissions has also risen hugely, and from 1992 to 1998 the number of non-elective finished consultant episodes rose by 28%. As a result there has been a significant increase in the ratio of nurses to finished consultant episodes (table). Measured in admissions instead of finished consultant episodes, the rise in workload seems lower, but referrals among consultants do generate real extra work for nurses. Changes in skill mix have been highlighted as one solution to nursing shortages.

The last nursing shortages in Britain, in the mid-1980s, and those of previous decades, occurred primarily because an increased demand for health care and staff outstripped available supply. This current cycle looks more problematic. It relates both to further increases in demand and to supply difficulties. Various supply factors—in particular, the ageing of the nursing profession and the dwindling pool of potential nurse "returners" (former nurses returning to paid employment)—are likely to constrain future supply,

Nursing workloads for acute, paediatric, and maternity services for 1990 and 1998 in England

	1990	1998
Qualified nurses:		
Total No	148 640	167 410
No per 1000 finished consultant episodes	21.4	17.5
Unqualified nurses:		
Total No	47 110	46 750
No per 1000 finished consultant episodes	6.8	4.9

The total numbers of nurses (except students), as whole time equivalents, in England were 336 520 in 1990, 337 603 in 1994, and 332 200 in 1998[3]

even though demand for health care is expected to continue growing.

Nursing supply and demand could become even more problematic in the next 10 years if there is no sustained approach to planned intervention.[4] The NHS nursing workforce is ageing—in this decade compared with the last, proportionately more nurses will be in their 50s and beginning to consider retirement (fig 1). Coupled with increasing demand for health care, the impact of retirement rates could worsen the imbalance between supply and demand.

When nursing shortages hit the headlines in 1998-9 the government took action. The NHS Executive set up a recruitment and retention unit. National advertising campaigns, efforts to attract returners, and an emphasis on friendly flexible working were underpinned by the full implementation of the Pay Review Body awards. National targets were set by the secretary of state for health to employ "up to" 15 000 more nurses in the NHS.

Some progress has been made. The number of applicants to pre-registration nurse education has grown rapidly over the past year. The NHS Executive claims that the nurse returner scheme is working, but this represents only a partial solution to the problem of shortages. A longer term improvement in the planning and career structure of the nursing workforce is also required.

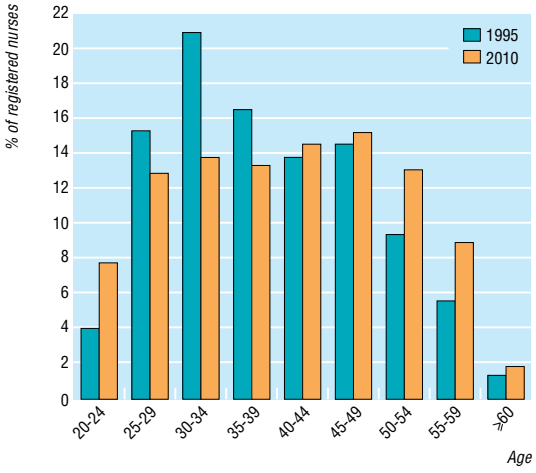

Fig 1 Age distribution of registered nurses (whole time equivalent) in United Kingdom in 1995 and 2010 (predicted). Adapted from Buchan et al[4]

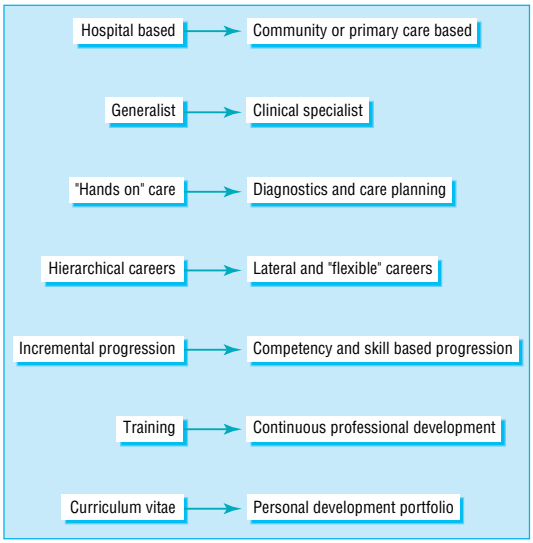

Fig 2 Changing lexicon in nursing careers

Changing labour market for nurses

Nursing shortages relate not only to numbers but to an overall skills deficit in the nursing workforce. Staff may have to stand in for senior staff or cross professional boundaries to cover vacant posts. This may affect doctors, who may find some of the burden transferred to them. A pledge to fund 15 000 more nurses may grab headlines, but it is specific nursing skills and competencies that employers are looking for, not just pairs of hands. These extra nurses may not necessarily be in the right place or have the right skills to contribute fully to the NHS. Nursing careers and career structures are changing (fig 2). Many nurses will have to seek further training if they are to maintain competency in this changing environment.

This need for change is made more pressing by a rising demand for nurses with extra skills to staff new services—such as NHS Direct (a telephone health helpline), primary care trusts, and nurse led minor injuries units—and to staff existing but expanding services, such as intensive care. Higher grade nurses are also increasingly sought across a range of specialties and as nurse practitioners, nurse consultants, and in other posts requiring high level professional autonomy and advanced skills. Although no complete, centrally held database of the number or distribution of these new roles exists, the number of such posts is increasing and the scope of their roles is expanding. NHS Direct already employs several hundred nurses, and in January this year the first 141 nurse consultant posts in England were announced. Expansion has been fuelled not only by the realisation that nurses can do some tasks as well as or better than doctors, but also by the need to reduce junior doctors' hours.

Nurses are now in a sellers market for their skills and can choose where and how long they work. Staff shortages are not uniformly distributed around the country. The south east of England, particularly London, continues to experience the greatest difficulties, but even within difficult local labour markets, hospitals vary greatly in their ability to retain experienced nurses, depending on their employment policies and

culture. More evaluation is needed to identify why some hospitals, even in difficult labour market conditions, attract and retain nurses better than others.

Integration of planning processes

The current methods of workforce planning in the NHS are under internal review by the Department of Health, which was stung into action by criticisms made by the House of Commons Select Committee on Health.[5] The absence of "joined up" planning between the Medical Workforce Standing Advisory Committee, and the existence of "de-linked" mechanisms for nurses and other professional groups, was highlighted as a significant shortcoming. Decisions on numbers of doctors and on numbers of other health professionals to be trained were being taken in isolation, without proper consideration of the knock-on effect on other professions. The proposed solution by the government is "integrated workforce planning," but this lacks a clear definition.

Focusing narrowly on the short term needs of nursing will not be enough to improve workforce planning. We need to develop our capacity to assess demand and to understand how to integrate the planning of the different professions in health care. Improvements are also needed at an operational level for day to day allocation of staff and decisions on the best mix of staff to deliver care.

Three main levels of integration require examination. Firstly, we need better integration of workforce planning and operational planning at trust level to improve the link between service delivery and staffing requirements. This should be more readily achievable with the three year NHS planning cycle that is becoming the norm and with the economies of scale that can be gained through cooperation and shared services among trusts.

Secondly, a widely recognised need exists to improve the integration of the process of planning of different groups of workers (such as nurses, doctors, and those in professions allied to medicine (PAMs)) to take account of skill changes (such as the new and advanced roles for nurses). This should involve the education sector and should include joint training for different professions. The Department of Health in England has already merged its medical and non-medical workforce planning capacity, and in Scotland the Health Department has established an Integrated Workforce Planning Group.

Thirdly, the planning process should have as a main objective an integrated workforce of multidisciplinary teams. This is likely to entail increasing use of generically trained healthcare assistants in some care environments, working with professional nurses.

The targets to increase the numbers of NHS nurses and doctors have concentrated the minds of civil servants, education consortiums, and NHS managers. However, because of the focus on 15 000 "new" nurses, there may be insufficient debate about where these nurses should work and what skills they should have. The challenge now is to take advantage of this target and use it to establish a more effective and integrated approach.

A new career structure for NHS nurses?

Integrated planning is necessary, but not sufficient. Getting staffing numbers right is part of the process, but staff have to be recruited, retained, and motivated. The government is proposing major changes to the NHS pay system under the rubric of Agenda for Change. The Agenda for Change promises to provide fairer and more responsive pay and career structures for NHS staff, which will facilitate career progression. This is a priority, but the government has to weigh up the political and economic costs and consequences of any fundamental shift in the way that pay is determined.

The Department of Health in England has also recently launched a strategy for nursing (Making a Difference) which proposes a four level career structure: healthcare assistant, registered practitioner, senior registered practitioner, and consultant practitioner. It proposes that progression would be determined by an assessment of responsibilities and competencies. The introduction of a competency based framework at local level would represent a fundamental shift away from the current system of incremental progression within a national clinical grading structure.

This new system is intended to improve career opportunities for clinical nurses. The current government and its advisers should, however, look back at the successes and failures of the Conservatives. The last (Conservative) government made three attempts at changing the way nurses were paid. Two failed: neither local pay nor performance pay became a reality for the vast majority of NHS nurses. Clinical grading was implemented in 1988 but was problematic; although improved career prospects were expected, the new grading foundered because of underfunding and mismanaged implementation. If the system proposed under the Agenda for Change is to be effective, it will need more attention in the design phase and more management capacity in implementation than was the case with clinical grading.

New pay systems can have high implementation costs. Poor implementation can produce dissatisfaction, public relations problems, and many grading appeals. A second lesson from the past is that it is important to have Treasury support and to ensure that the new pay system is congruent with NHS management requirements and capacity.

The Treasury has never been keen on unfettered local pay bargaining in the NHS, particularly in conditions of a labour market in which demand exceeds supply. It fears that local pay would allow unions to exploit problems in the local labour market by using their bargaining power to highlight anomalies and use pay increases in one trust to ratchet up pay in others. The Agenda for Change strategy avoids this, by maintaining a national structure. Old-style "local pay" is now off the agenda, replaced by "flexibility within a national framework," which so far has kept both unions and the Treasury at the bargaining table. It is important, however, that the price of keeping the Treasury at the table is not a promise of cost savings or efficiency improvements.

It is easy to dismiss the last government's failure over local pay as simply an expensive distraction with a

huge opportunity cost in terms of management time and effort. It indirectly prepared the ground for a more considered review of the way NHS pay and conditions of employment are determined. The Agenda for Change has the potential to take this considered approach.

Conclusions

The rapid change in many aspects of the nursing profession, and the changing boundaries of work between doctors and nurses, has produced a challenge that the NHS has not met fast enough and which it must now address. The variable and often poor quality of workforce planning, its lack of coherence or relation to other plans, the failure to consider the private sector, and changes in workload have been contributory factors. A further problem is that the NHS has a tendency to focus on the costs of training and education, without considering the costs associated with staffing shortages. Perhaps of greatest concern is the requirement for year on year efficiency gains. This has led to a cycle of increasing pressure, often in the form of unpaid and unrecognised overtime. Workload has increased and skill mix has been diluted as the search for efficiency has turned into simple cost cutting. Evidence is emerging that a dilution in skill mix, level of workload, and other aspects of the work environment have important implications for quality. Developing a systematic and integrated approach to workforce planning can deliver improvements in the mid to long term, but some urgent and concerted action is also required in the short term.

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3 Department of Health. *Statistics Bulletin*. London: DoH, 1998. (Bulletin No 1999/12).
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5 House of Commons Select Committee on Health. *Third report: future NHS staffing requirements*. London: Stationery Office, 1999.

For and against

Doctors and nurses should monitor each other's performance

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FOR "You used to work on ward 3. Do you remember me? I was on nights." The nurse approached me at the end of year house officers' party; it was 1981.

"I used to hate you," she added. She poured a pint of beer over me. I was too startled by this informal appraisal method to reply suitably. Later, I learnt I had incurred her wrath by reacting to the incessant inhuman bleep by arrogantly snapping at her part in my misery.

Only the minds, not the hearts, of the professions are behind being appraised. I am a general practitioner, and most of us cling on to "independent status," best viewed as a kind of complex performance related pay, with certain small freedoms and certain obligations. Senior hospital doctors have different obligations and less freedom but still have the privileges of rank. Not, perhaps, a free car parking space but certainly team leadership, care of employees, and involvement in hospital developments.

This aloof position that we hold permits serious appraisals to be seen as something to be done to others, not oneself. Indeed, status is a barrier behind which we cower.

That the threat is perceived so deeply shows how unconfident we are as doctors. Yet what aspects of our work are important to appraise? We leap to thinking of technical skills, diagnostic ability, prescribing effectiveness, and manual wizardry, and how could anyone but peers test that? (Actually, anyone with an objective testing tool could—a nurse, for example, or perhaps a manager.) But what of communication skills and teamwork attitudes, those education-speak phrases of the 1980s and 1990s?

Doctors can be evil, incompetent rogues and yet charm their way up the ladder to invincibility. So can nurses. Away from the Shipmans and the Allitts, we all know of generally well meaning and competent clinicians facing complaints in which a failure to communicate with patients and each other is a factor. The other clinicians, be they the same profession or not, will have valid experience and views on what might have gone better. But in our culture blame is passed around until the music stops and someone has to face it. Maybe feedback from a different profession would feel a bit less like criticism.

To expect a peer, a person of equal standing who purportedly knows what is involved in the job, to be the only source of feedback is like asking for forgiveness. As if my rudeness at dawn to the nurse whose name, if I ever knew it, I have forgotten is allowable because I was soaked in fatigue. It isn't—and neither was her lack of knowledge of my circumstances.

The roles of doctor and nurse are blurring. My practice nurse gave the doctors a tutorial on asthma last week, and is our team's expert. I fancy I might be skilled at serious mental illness, but we all do hypertension, immunisations, listening, terminal care, and much else. The nurse's view on me is as important as my partner's view on me, and mine on her. The issue is whether any of this will result in change. Let's hope so.

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