

NHS staffing shortages

Why do politicians struggle to give the NHS the staff it needs?

Bill Morgan
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About this report

This report was funded by The King's Fund and Engage Britain. It was independently developed, researched and written by the author and all views are the author's own. The author undertook this project between May and October 2022.

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Foreword

Coming on top of major challenges of increasing demand and long waiting times, the health service's inability to recruit the staff it needs is nothing less than a crisis. It's a crisis that has developed over many years and is an increasingly major concern for people who depend on the NHS – patients and the public. Engage Britain's recent People's Panel on health and care showed that the general public see recruiting, retaining and training the workforce as both the biggest cause of, and most important solution to, the challenges facing the system. But for several years now, there has been no clear plan to address the crisis and the staffing gaps have continued to worsen. This can only undermine public confidence in our political system's ability to tackle the issues that matter most in their lives.

We need new thinking if we are to break this pattern. We commissioned Bill Morgan to write this independent report, not to give us 'the solution', but to provide new insights and shine a spotlight on an under-recognised point in the policy process where debate often gets stuck. It invites you the reader to flex your thinking muscles by exploring one big issue – how politics interplays with workforce policy – and asking, does it have to be this way?

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Author's foreword

On 26 April 2022, the UK government defeated an attempt during the passage of the Health and Care Act to force it to publish independent assessments of the number of health care staff that the NHS will need in the future (*Hansard (House of Lords) 2022*). The defeat came despite a cross-party campaign that more than 100 health organisations, including The King's Fund, endorsed.

The government's hostility to the campaign seemed bewildering. The NHS's longstanding lack of staff has been one of its greatest – ever-present – challenges, and those supporting the campaign argued that independent forecasts would help ensure we train enough staff in future.

The government's position was even more unfathomable given that the challenges facing the NHS workforce are one of the public's greatest concerns. Engage Britain, through its People's Panel, has identified the failure to recruit, train and retain sufficient health and care staff as the public's top priority.

The NHS workforce shortage is therefore one of those nationally important issues that has been around for decades, but has never been resolved – because, for whatever reason, the UK political system seems unable to respond properly to this very real public concern.

Why is this? What is stopping it from being sorted out? And can anything be done?

To answer these questions, The King's Fund and Engage Britain commissioned this paper on the politics of the workforce challenge. It is intended for all those with an interest in health and social care, particularly for those who are in or aspire to enter government.

The paper aims to identify why ministers are unlikely to take meaningful, long-term action to address NHS workforce shortages – even when doing so would be in their interests – and why there is a risk that even when they announce their intention to do so their plans may be derailed. It seeks to shine a light on the cross-government dynamics that impede a sustainable solution, and to help politicians understand why – although it would seem evidently popular for them to train more NHS staff – they find it problematic to do so.

Although the conclusions of this paper are the author's own, it is the product of the input of many individuals who have given their time to contribute to it, some of whom are willing to be acknowledged, and some of whom would rather not. Those who are happy to be acknowledged are Mike Barnard, David Behan, Derek Bosworth, James Buchan, Andy Coulson, Richard Douglas, Paul Doyle, Andrew Foster, Shaun Gallagher, Sara Gorton, Dido Harding, David Hare, Fiona Hill, James Kanagasooriam, Andrew Lansley, Jo Lenaghan, David Metcalf, Alan Milburn, David Nicholson, Ben Nunn, Mike Richards, Nick Seddon, Richard Sloggett, Hugh Taylor, Nick Timothy, Claire Warnes and Rebecca Wilde.

The paper could also not have been produced without the expertise and insight of those at The King's Fund, Engage Britain and the Institute for Government – including Siva Anandaciva, Suzie Bailey, Alex Baylis, Alasdair de Costa, Nick Davies, Nick Downes, Francis Elliott, Miriam Levin, Julian McCrae, Richard Murray, Emma Norris, Jill Rutter, Nihar Shembavnekar, Nick Timmins, Sally Warren and Joachim Wehner – nor without the members of Engage Britain's People's Panel.

Thank you all.

Introduction

The NHS is beset by chronic workforce shortages. At its inception, the NHS was estimated to have 30,000 too few nurses and midwives (Rivett undated a), and Aneurin Bevan wrote at the time that ‘the situation is extremely serious already [and] it is likely soon to become critical unless thousands of new recruits can be obtained quickly’ (Ministry of Health 1945). There has been no decade since the 1940s in which finding more staff has not been a pressing priority (for an extensive history of the NHS, including its staffing issues, see Rivett undated b). This paper seeks to understand why.

The paper begins by briefly describing the approach taken to its development, before setting out:

- the scale of the problem and the impact that it has
- what causes the problem and why – politically – it has proven so hard to fix
- three possible solutions.

Developing this paper

This paper has been developed through a five-stage process.

- First, semi-structured interviews were held with people involved directly or indirectly in NHS workforce policy and planning over a period of some 20+ years, to provide helpful direction and clarity on the areas that the paper could most usefully focus on.
- Second, a snowballing literature review was completed, using The Health Foundation’s report *Fit for purpose?* as a starting point (The Health Foundation 2016).
- Third, a hypothesis to explain the problem was stress-tested through a workshop with experts from Engage Britain and The King’s Fund, and through further semi-structured interviews – again with those involved in NHS workforce planning and policy, and also with others involved in related areas of policy.
- Fourth, possible solutions were developed, and refined through discussions with experts from Engage Britain, The King’s Fund and the Institute for Government. The political aspects of the solutions were also tested with Engage Britain’s People’s Panel and with experts in political communication.

- Fifth, the paper was drafted and finalised, and then quality-assured by experts from The King's Fund.

The paper is chiefly focused on the political barriers that have led to the failure over time to secure a sufficient supply of NHS staff. It does not therefore address non-political aspects of workforce planning, such as its technical design. Nor does it cover shorter-term staffing issues, including questions of pay and non-pay retention initiatives (such as reform of doctors' pensions), and questions of administrative and technological support to help staff do their jobs – where the principal barriers are those of feasibility and affordability rather than being mainly political in nature. These are nonetheless critically important to ensuring we have a sufficient number of staff, working effectively.

The social care workforce is also out of scope of this paper. This is admittedly a large gap, given the level of interdependency between the social care and health care systems, and it should be clear that fixing the shortage of social care staff needs to be accorded the same priority as fixing the shortage of NHS staff. However, responsibility for planning and training the formal social care workforce in England alone sits with the almost 18,000 social care providers ([Skills for Care 2022](#)) – and the sector as a whole is also reliant on a large, informal workforce – and so the policy problem in social care is of a different order of complexity. Engage Britain and The King's Fund are, however, exploring it separately.

The scale of the problem

The NHS has rarely had the staff it needs. The most recent statistics for England – from September 2022 – report a vacancy rate among doctors of more than 7 per cent and a vacancy rate among nurses of almost 12 per cent ([NHS Digital 2022c](#)). Just four months earlier, in May 2022, the same figures stood at less than 6 per cent and at 10 per cent respectively ([NHS Digital 2022c](#)).

These shortages mean that some of the government's key manifesto commitments will not be met. The government has admitted, for example, that it will not hit its 2019 pledge to recruit an additional 6,000 general practitioners (GPs) (Tilley 2021). Indeed, the number of GPs in England has remained stubbornly flat for years, standing at 35,257 in July 2022 ([NHS Digital 2022a](#)) – a net increase of fewer than 1,000 GPs above the 34,392 we had in September 2015 ([Bostock 2018](#)).

The shortages are not only among doctors and nurses, however. The House of Commons Health and Social Care Select Committee has also noted shortages in almost every other health care profession, including speech and language therapy, dietetics, pathology, midwifery, sexual and reproductive health care, occupational health, dentistry and pharmacy ([House of Commons Health and Social Care Committee 2022](#)).

The impact that these shortages have is manifold. With a limited number of staff, the overall capacity of the NHS to deliver the quality and quantity of care that people expect becomes limited. So when the NHS in England has a waiting list of almost 7 million people ([NHS England 2022b](#)) – and one that is growing – it is plain to see (and a lesson of the 2000s) that a precondition of being able to turn the situation around is having enough staff.

The shortages also have a direct impact on those staff who are working in the NHS. Health care is a stressful profession, and demanding that NHS workers cope with staff shortages – on top of everything else they are asked to do – harms their wellbeing, increases sickness absence (rates of which have grown from 4.37 per cent in 2020 to 5.20 per cent in 2022 ([NHS Digital 2022b](#)) and exacerbates challenges of staff retention (with leaving rates for health care staff now growing, after reductions seen during the Covid-19 pandemic ([Palmer and Rolewicz 2022](#))).

The shortages are counterproductive, both now and in the future. They mean, for example, that nurses will be spending time today trying to find staff when they

could be providing patient care. And looking to the future, NHS leaders wishing to develop new and more efficient and effective models of care, and different ways of staffing them, will find a lack of ready, available and willing health care professionals to help them do so.

In many sectors, a shortage of employees equips employees with a bargaining advantage over employers when negotiating their terms and conditions. However, in health care, because the government is in practice a single employer, it offsets this employee advantage through the national negotiation of employment contracts – a situation that may suit both the government and the trade unions they negotiate with, but which leads to the agreement of employment contracts that are necessarily the result of pragmatic national compromises rather than being reflective of local labour market conditions.

The chronic shortages of staff thus divorce decisions over terms and conditions from the needs of employers, removing from employers an important tool to help them respond to the workforce shortages they face locally. In regions where it is difficult to recruit and retain staff, for example, national contracts allow for a Recruitment and Retention Premium (RRP) – a pay supplement – to be paid. But because national terms dictate that it must be paid to all employees rather than only for hard-to-fill vacancies, in practice it is little-used ([Charlesworth and Lafond 2017](#)).

The resultant inflexibility in terms and conditions contributes directly to the large secondary labour market in temporary staff, which has a negative impact on the stability and continuity of care ([Sizmur and Raleigh 2018](#)), and which is a more expensive solution than permanent staff because both staffing and agency costs need to be met. Spending on temporary staff was estimated at £2.38 billion in 2019/20, and has continued to rise since then, with a further upturn in demand for temporary staffing seen recently as the elective recovery programme got under way ([Department of Health and Social Care 2022b](#)).

Chronic staff shortages therefore impose significant burdens on the NHS and its ability to cope with change. They constrain the NHS's capacity, impede reform, result in insufficiently sensitive employment contracts and demoralise the staff the NHS has – who then exit into an agency staffing sector, or leave the NHS entirely.

Why the problem exists

To a lay person, it is difficult to understand why these chronic staff shortages exist. There is no paucity of young people wishing to go into the medical, nursing and other caring professions – and many are highly motivated to achieve their ambitions. The NHS's leaders experience the impacts of staff shortages every day – and are focused on mitigating them. The Treasury is aggrieved by the NHS's agency staffing bill and its sickness absence rate (as well as the NHS's performance overall) (personal communication) – and adequate staffing solves these problems. And finally, politicians know that hiring more NHS staff is one of the most popular policies they could adopt – and they put it in their manifestos ([Conservative Party 2019](#)).

Given that politicians want to recruit more staff, that it seems to make financial sense to do so and that people are willing to be trained, it would appear irrational for the NHS to ever experience staff shortages – and yet it almost always does.

These shortages exist because of three broad groups of challenges, each of which politicians find hard to overcome.

Difficulties in forecasting

Planning for the future health care workforce is difficult. At the heart of this difficulty is the length of time it takes to train a health care professional – 3 years for a nurse, 10 years for a GP and the best part of 15 years for a consultant ([The Health Foundation 2016](#)) – and the likelihood that, by the time those in training enter the workforce, the world will look very different from the one that workforce planners had prepared for.

The uncertainties are multifaceted. First, technological developments may render skills gained in training redundant by the time health care professionals enter the workforce – particularly so for doctors. We do not know, for example, whether in 15 years' time we will need more or fewer oncologists, because we do not know where the path of technological development will lead.

Second, the working preferences of staff may change in ways that are hard to predict. The NHS is not immune, for example, to the economy-wide pandemic-related disruption to the labour market, and the trend towards greater flexibility it

has ushered in ([Gasgoigne 2021](#)). Exactly where working preferences will settle as we emerge from the pandemic is as challenging for NHS workforce planners to predict as it is for organisations operating in other sectors.

Third, unforeseen legal and policy changes may have an impact on the needs of the health care workforce. In the early 2000s, for example, two European Court of Justice rulings clarifying aspects of the European Working Time Directive created an unforeseen shortage of up to 12,000 junior doctors ([Hansard \(House of Commons\) 2004](#)). In 2013, the policy response to the publication of the Mid Staffordshire Hospital public inquiry ([Mid Staffordshire NHS Foundation Trust Public Inquiry 2013](#)) – which encouraged the recruitment of more nurses in pursuit of safer care – conflicted with the previous (and optimistic) planning objective of seeking greater efficiency from a smaller nursing workforce, leading to nursing shortages ([The Health Foundation 2016](#)). And today, the court-ordered ‘McCloud remedy’ – which addresses unlawful age discrimination in the implementation of previous public sector pension reforms – is likely to lead some health care professionals to exit the workforce earlier than anticipated. These kinds of events are hard to build into workforce forecasts.

Fourth, the composition of the workforce may change in ways that are difficult to plan for. For example, the pandemic led to 17,000 people signing up to a pilot ‘NHS Reservist Programme’, which is now being expanded ([NHS England 2022a](#)). The creation of such a programme, and how it may evolve in future, was, and is, difficult to predict.

To circumvent these problems, national workforce planners lean on historic trends as the most reliable guide to future workforce needs (second-guessing local workforce planners, who are more likely to be concerned about affordability, in the process ([The Health Foundation 2016](#))). If key workforce groups have grown at, say, 3 per cent over time, then national workforce planners assume that it is likely that this trend will continue in future. Given the degree of uncertainty, this is a reasonable approach to take – but it is by no means a perfect one, because it means that the organisation of the present health care system frames the workforce of the future ([Rees et al 2018](#)).

Workforce forecasting is therefore difficult per se, but the task that workforce planners face is made much more difficult by the fifth and final reason for the difficulty in workforce planning: organisational disruption, typically triggered by wider NHS reorganisations in which the workforce planning function is treated as an afterthought. Over the past 20 years – a period not much longer than the time it takes to train a consultant – the NHS’s workforce planning function has changed

materially five times. Workforce development confederations, created in 2001, were consolidated into England's then 28 strategic health authorities in 2003, which were themselves rationalised into 10 strategic health authorities in 2006, and then abolished in 2013 in favour of Health Education England, which in 2023 will be merged into NHS England.

The lessons from this turbulent history are threefold. First, workforce planning cannot be separated from finance and service planning, particularly over a near-term (three-year) and thus relatively predictable planning horizon. When it has been in the past, the NHS's ambitions to develop new services have struggled because of workforce shortages, and workforce planners' well-intentioned initiatives – such as the creation of the 'physician associate' role to sit between doctors and nurses – have foundered because of a lack of uptake by frontline services (Watkins *et al* 2019).

Second, and although it is sensible to join workforce planning to finance and service planning, whenever they have been joined together in the past, long-term education and training budgets have been raided to tackle short-term pressures: in 2005/6, for example, strategic health authorities underspent their training budgets by £150 million as deficits in hospitals grew (House of Commons Health Committee 2006). The plan now to merge Health Education England into NHS England (although it may help to align workforce, finance and service planning) will thus need to be accompanied by some protection of its budget to maintain investments in training.

The third lesson is that ministers tend not to involve themselves closely in workforce planning policy, not least because of the political risks. Yet it is self-evident that the risk of getting workforce forecasting 'wrong' can be lessened by making the education and training of health care professionals more adaptable and flexible – and there is no shortage of suggestions for how to do so (see box below).

Ideas for more flexible and adaptable training

- Reduce the time it takes to train a doctor or a nurse, either by reducing the amount of time for training set out in legislation, or by increasing the number of doctors and nurses trained through shorter postgraduate courses.
- Move the point of full registration as a doctor forward by a year, to the point of graduation.

- Introduce an apprenticeship-style final year of medical school.
- Develop the sub-consultant-grade doctor role, so that doctors entering training do not necessarily see a consultant position as the pinnacle of their medical career.
- Establish opportunities to move between the different professions, so that it is easier and takes less time for a nursing associate to train as a registered nurse, and for a registered nurse to train as a doctor.
- Rebalance the degree of specialisation in the training process, so that broad-based skills that clinicians might need throughout their career are taught upfront and specialised knowledge is delivered through ongoing training and credentialing processes.
- Increase the level of multi-professional training so that staff become used to practising at the top of their licence when they enter the NHS, and to working in multi-professional clinical teams.

Note: This paper offers no views on the merits of any of these ideas.

However – and by way of a thought experiment – if you place yourself in the mind of a typical health minister (of any political persuasion), it should be equally self-evident that embarking on any such reform is extremely hazardous for a politician. Health care professionals will always have the upper hand over a minister in determining the clinical risks of any changes to their education and training – and importantly the public will trust them more to make this judgement. A minister will thus find that any efforts they make to seek to lead such changes themselves will rapidly erode their political capital.

Ministers might also try to improve the quality of the workforce forecasts by publishing them, thus exposing them to greater scrutiny and academic rigour. This, however, leads us back into the debates during the passage of the Health and Care Act, which were referenced in the Foreword, and to the efforts to publish forecasts that the government – and particularly the Treasury – resisted. Even if our typical health minister wanted to publish these forecasts in the future, they would continue to find a Treasury reticent to do so for fear of losing control over staffing numbers in the NHS – just as the Treasury fears it has already lost some control over pay through the system of independent pay review bodies (personal communication). Given that 70 per cent of NHS England's budget is spent on salaries, the Treasury sees this as a significant fiscal risk (personal communication).

A tendency towards undertraining in the United Kingdom

Despite these difficulties in the workforce forecasting process, they are not sufficient to explain the chronic shortage of staff the NHS faces. If workforce forecasts are likely to be wrong, then they should at least be wrong in both directions: delivering us too many staff on some occasions, rather than always too few. Another reason for the chronic shortages we experience is because we simply fail to train enough staff in the UK. And again, the reasons why are multifaceted and politically challenging to overcome.

One reason is linked to the challenges in workforce forecasting, and in particular its inability to predict the number of staff we may need with certainty, and its reliance on historical workforce patterns as the best guide to future needs. For the Treasury, which is rightly concerned with seeking to improve the productivity of the NHS workforce, and which also invests significantly in the training of health care professionals (it costs more than £60,000 to train a nurse, and more than £500,000 to train a consultant ([Jones and Burns 2021](#))), getting these decisions wrong generates real fiscal danger. It is better, therefore, for the Treasury to err on the side of caution, to assume a high level of productivity from the future workforce in calculating our future needs and thus to run the risk of delivering an undersupply of staff rather than an oversupply. (As an aside, the Treasury's over optimistic productivity assumptions have repeatedly failed to materialise: over the past 40 years, the Treasury's initial NHS spending plans were for average annual growth of 2.7 per cent but have ended up being 4.1 per cent ([Office for Budget Responsibility 2022](#)).)

An oversupply is doubly concerning for the Treasury because of the fear of supply-induced demand. This is not a theoretical risk: in Germany, a decentralised workforce planning system has, over time, led to an oversupply of doctors, and hence to the creation of jobs to employ them and to the relative overmedicalisation of health care provided in the country (Britnell 2019). Indeed, the Treasury fears that the expansion of medical school training places over the past five years might lead us into precisely this position in the future (personal communication). Again, for the Treasury, it is better to undershoot than overshoot.

It is very challenging for our typical health minister to fight this mindset, based – as it is – on legitimate fears. Other factors also reinforce it: the Treasury has longstanding concerns with the value for money of the education and training budget, including the dropout rate from nursing courses (which on average is 24 per cent but can be up to 50 per cent ([Buchan et al 2020](#))) – and it would prefer to see greater conditionality attached to the taxpayer support provided to students

so that they commit to working in the NHS for a period of time after graduation (personal communication). The Treasury would also like the budget to be used to train a more flexible and adaptable workforce in the ways set out above (personal communication). Paying to train staff outside the UK – in countries where costs are lower – has also been considered. But all these reforms are politically problematic to take forward.

What if our typical health minister did manage to win Treasury agreement, possibly by conceding to some reforms? What would they do with the larger education and training budget they had secured?

One risk – and it is a very real one, because it has happened before – is that our health minister, for exactly the same reasons why spending on public health and capital gets squeezed, diverts the funds they have won away from education and training and towards addressing the short-term needs of the NHS. Counterproductive though this is, they cannot really be blamed for taking this step: the electorate is more likely to reward action to tackle, for example, ambulance response times and NHS waiting lists at the next general election than it would action to increase the number of doctors and nurses in training – the latter would only yield a benefit at the election after the next one, or even the one after that. In recent years, with day-to-day NHS funding inside a ringfence and education and training spending outside it, we have seen this dynamic play out in sharp relief: since 2013/14 Health Education England's budget has stayed broadly level, while NHS England's has increased substantially.

A further political risk for our typical health minister – and one that may strike people as odd – is that the professions themselves sometimes resist increases in training. This is through:

- fear, as the British Medical Association put it in 2008, 'of the overproduction of doctors with limited career opportunities' (Cole 2008)
- concern that high-quality placements might not be available for those entering training, given the existing workforce may not have the capacity to help oversee them
- a desire to see taxpayer support for students not being spread too thinly (for example, the Royal College of Nursing's campaign in recent years to see nursing bursaries restored was successful – but ultimately led to a return in the cap on nursing training places).

Our typical minister, therefore, in order to win increases in funding for education and training, would have to: win a fight with the Treasury (inevitably conceding to demands to make politically challenging reforms to the education and training system in the process); fight their own political instincts to divert the extra money towards tackling the NHS's short-term problems for which they are held more directly accountable; and then potentially face criticism for having done so by the very professional groups they are trying to help.

Insufficiently strategic use of recruitment from outside the United Kingdom

Even the tendency towards undertraining in the United Kingdom – coupled with the difficulties in workforce forecasting – is not sufficient to explain the NHS's chronic staff shortages, because international recruitment can always address staff shortfalls.

We should remind ourselves just how dependent the NHS is, and always has been, on this source. Just a year after the NHS's creation, the Ministries of Health and Labour launched a campaign to recruit nurses from the Caribbean ([Snow and Jones 2011](#)). A random sample taken from the Medical Directories of 1953 and 1955 found that more than one in ten doctors at the time were trained outside the United Kingdom ([Simpson et al 2010](#)). Since 1990–1, the number of nurses trained outside the United Kingdom has accounted for no less than 10 per cent and as much as 53 per cent of the overall annual number of new nurses joining the nursing register ([Shembavnekar and Buchan 2022](#)). And today, more than one in six nurses and almost one in three doctors working in the NHS trained outside the United Kingdom ([Organisation for Economic Co-operation and Development 2022](#)).

With this ability to recruit internationally, and a track record of doing so, why does the NHS face staff shortages?

The first, and most obvious, reason is that migration policy is not set with the NHS's interests in mind, but for broader reasons of policy and politics. In the early 2010s, for example, the-then government pursued a relatively restrictive policy targeting net migration, even when this exacerbated staff shortages in the NHS ([Migration Advisory Committee 2016](#)). (To take an alternate example, the relatively open immigration policy of the early 2000s led to the NHS recruiting staff far in excess of government plans, and to the rushed imposition of a series of controls on the inward migration of health care professionals in 2005 and 2006 ([House of Commons Health Committee 2006](#)).)

The second reason is that, even when migration policy supports the NHS's workforce requirements – as today, via the existence of a Health and Care Worker visa ([Department of Health and Social Care 2021](#)) and with all health care professions on the Shortage Occupation List ([UK Visas and Immigration 2022](#)) – other elements of domestic regulatory and NHS policy continue to be misaligned, such as restrictions on the ability of regulators to increase capacity to test the competency of health care professionals from outside the UK ([Campbell 2022](#)). The application process for such staff can also be overly burdensome ([NHS Providers 2021](#)).

The third reason is that there are some staff groups for which international recruitment does not offer a solution. Some disciplines face global shortages (notably mental health nursing), and recruitment from outside the United Kingdom cannot readily address shortages in general practice because few other countries follow the UK model of primary care ([NHS Confederation 2022](#)).

The final reason, and one that should be plain to all, is that embracing international recruitment is not politically painless. Our typical minister, seeking to expand such recruitment, would encounter a Home Office not only sensitive to immigration on political grounds but also concerned with the extra workload for UK Visas and Immigration – and furthermore a trade secretary potentially unwilling to trade away the UK's recognition of other countries' health care professional qualifications too lightly. (The independent health care professional regulators may also want assurance for such moves on patient safety grounds, and the final decision on such recognition rests with them.)

Having fought these internal political battles, our typical health minister would then have to win in the court of public opinion:

- reassuring right-leaning voters that the reliance on international recruitment is not denying UK citizens career opportunities in the NHS, and is not undercutting the wages of staff trained in the UK
- reassuring left-leaning voters that the UK is not taking staff from lower-income countries that need those staff more, given the World Health Organization's projected global shortfall of 15 million health workers in 2030 ([World Health Organization undated](#)).

Politically, therefore, ministers spurn recruitment from outside the UK as a long-term solution to the NHS's workforce needs – preferring instead, as Health Education England's draft workforce strategy did in 2017, to champion the aim of long-term self-sufficiency ([Health Education England 2019](#)).

Political solutions

The three broad challenges in securing enough NHS staff described in the previous section – difficulties in workforce forecasting, a tendency to undertrain staff in the UK, and the insufficiently strategic use of international migration to compensate – are each exacerbated by political factors. To recap, politicians are reticent to publicly accept recruitment from outside the UK as anything other than a short-term fix when the NHS is in distress, and so the NHS's historical reliance on international staff has never been planned for strategically. Politicians prefer instead the relative political safety of aiming for self-sufficiency in the staff the NHS needs, but multiple factors force the NHS towards undersupply. Steps that could be taken to mitigate the challenges in workforce forecasting are deemed politically unpalatable.

There are no easy solutions to these rather intractable problems. If there were, they would have been implemented by now. But, and in addition to the many small policy improvements that could be made to improve the system, we can at least consider some high-level political solutions that might help politicians escape the traps that cause staff shortages.

In doing so, we should keep in mind the kind of workforce planning system we want to see – one that:

- is capable of delivering a modest oversupply of staff (thus supporting staff wellbeing and innovation in staffing models)
- is capable of predicting future workforce needs as accurately as possible, and of training a flexible and adaptable workforce
- is aligned and integrated with the NHS's service and financial plans
- delivers value for money
- ensures that students trained in the United Kingdom are not left without jobs in the NHS.

Three possible high-level solutions could be considered.

Transparency in workforce forecasts

To start, workforce forecasts could be made public – along the lines that parliamentarians proposed during the debates on the Health and Care Act:

5-, 10- and 15-year rolling forecasts, perhaps published as often as every other year (in recognition of the speed of technological and other changes that might affect forecasts).

The rationale for doing so is sound: to improve the quality of workforce forecasting by exposing it to external challenge; and to bring to light the assumptions – about future demands on the NHS, the future productivity of the workforce and the future level of international recruitment – the government is making when determining its investments in training.

But the Treasury has already proven hostile to such transparency, so how could its concerns be overcome?

First, the workforce forecasts could be expressly designed to provide a reasonable range of future staffing needs, based on differing assumptions for the level of funding available to the NHS, and for the productivity of the workforce, in order to yield a range of scenarios – none of which would bind the Treasury.

And second, the forecasts could be published deliberately with a view to provoking debate on the need for greater productivity from the health care workforce, and how this can be delivered. The Treasury has in the past permitted long-run workforce forecasts to be published on occasion, precisely with this end in mind – as in Health Education England’s draft workforce strategy of 2017 ([Health Education England 2019](#)) – and might therefore be persuaded to do so again.

So if the Treasury was biddable, how could we ensure that a future government does not turn its back on transparency when it no longer proves convenient – as was the case with the Centre for Workforce Intelligence, which produced such forecasts transparently but was abolished by the government in 2016?

To mitigate this risk, the forecasts could be developed on a UK-wide basis and an obligation to publish them could be set out in law and placed on all four governments of the UK, provided that they all consented to it. This might itself be politically problematic – given that the four governments are of different political persuasions – but there is a sound theoretical justification for taking this approach, given that the UK is a single market in health care professionals. And there is also a more cynical reason, insofar as if the four governments could be persuaded to establish such a system in the first place, then any attempt to dismantle it subsequently would require the unanimous agreement of four different governments to do so.

An independent workforce-planning organisation

A further solution – building on transparency in forecasting – could be to establish an independent workforce-planning organisation. Such an organisation could be tasked with predicting the likely level of demand for health care services, and undertaking human resources planning to consider the blend of skills required to meet this demand. It could bring together professional bodies, NHS employers and universities to undertake these tasks – and consider options such as reconfiguring clinical teams, optimising the use of available clinical skills and exploring the development of new roles and their implementation in clinical practice.

The functions that an independent workforce-planning organisation could carry out would be for further discussion. It could advise ministers transparently on the training investment decisions they needed to make, it could provide commentary on the training investment decisions they chose to make or – at its most powerful – it could take decisions about training investments itself, independently from politicians.

The exact form that the workforce-planning organisation could take would be dependent on the functions it would be required to fulfil, but some options – explored with the help of the Institute for Government – are set out in the box below.

Possible approaches to establishing an independent workforce-planning organisation

Engage Britain’s deliberative work has shown that the public is highly supportive of an approach to workforce planning that is more independent of government, and that government promises to increase investment in education and training for the health care workforce would have greater credibility if they are underpinned by commitments to transparency and independence.

A high-level announcement that workforce planning will be ‘made independent’ might therefore suit the needs of politicians seeking success in an election, but further thought will need to be given to the kind of independent organisation that would result.

In creating a workforce-planning organisation, lessons can be learnt from the history of other independent bodies that advise government.

- The buy-in of both Number 10 and Number 11 to the need for an independent organisation is required from the start.
- Independent organisations can be most effective when their role is clearly defined, as with the Bank of England – although the narrowness of the Bank’s remit is unlikely to be replicable in respect of workforce planning.
- Effective leadership, with a respected Chair, is critical. Independent organisations are most likely to succeed if they establish an early track record of credibility and successful action, as with the National Institute for Health and Care Excellence (NICE) and the Office for Budget Responsibility.
- There are precedents for independent organisations capable of managing conflicting views (as would likely be the case for a workforce-planning organisation), such as the Low Pay Commission, that could be emulated.
- Cross-party support is helpful, but not critical. Rather – as with NICE – successive generations of officials and ministers need to remain convinced that the organisation is needed.

The Climate Change Committee might also provide a helpful template if the role of the independent workforce-planning organisation is to scrutinise and comment on the government’s education and training plans, rather than determine them. The Committee – which provides advice to government on carbon budgets (but does not have executive authority to set them) – has proven adept in ensuring that long-term, difficult issues are repeatedly addressed by government.

Finally, independent organisations have at times emerged following an independent inquiry, as was the case with the Warnock Committee and the subsequent Human Fertilisation and Embryology Authority. Given that there are many issues in workforce planning that are best considered without the involvement of politicians – such as how education and training might be reformed, or how new roles might be embedded sustainably into clinical teams – politicians might choose instead to establish a one-off independent inquiry that considers both short-term and longer-term solutions to the NHS’s workforce shortages, and that might then lead to the creation of an independent workforce-planning organisation to maintain focus.

Of course, the creation of an independent workforce-planning organisation would not be without risk.

- It might be captured by interest groups and become even more likely to embed unproductive ways of working than the status quo (and would run the risk that workforce planning decisions become detached from the NHS's needs).
- It might lead to training investment decisions that result in a frequent oversupply of health care professionals and the subsequent supply-induced demand that the Treasury is so keen to avoid.
- It could remove from ministers their democratic oversight of important decisions about the use of public money.

These risks would need to be carefully weighed against the potential benefits. First, there is potential for such an independent organisation to help politicians break free from the trap of underinvesting in education and training. And second – and possibly more importantly – there is potential for such an organisation to become a forum in which the professions themselves come together and explore what would otherwise be politically contentious decisions, such as making training more flexible and adaptable, and implementing new staffing models.

Accepting the need for international recruitment

A further 'solution', and one that would not require new institutions, would be to accept the NHS's historical reliance on recruitment from outside the UK as explicit future policy, and to plan accordingly – using the source as a means of delivering the modest oversupply of staff that is needed to support innovation in the NHS.

Accepting the NHS's reliance on international recruitment in this way would allow discussion about how to manage migration strategically: transparently encouraging migration if we foresee an emerging staff shortage, but imposing tighter controls if we risk oversupply. It would bring the NHS's staffing needs to the forefront of trade-deal negotiations, and it would help ensure that health care professional regulators in the UK have the capacity and capability to meet the NHS's demands for testing international recruits.

It would also permit the creation of a standing level of ongoing support for NHS employers to recruit staff from outside the UK – with, for example, contributions to the costs associated with this recruitment and high-quality induction programmes. As The King's Fund, the Health Foundation and the Nuffield Trust have all noted, NHS employers would benefit from regional and national programmes that provide economies of scale for these activities ([Beech et al 2019](#)).

Many low- and middle-income countries also welcome international recruitment because they benefit through the remittances they receive from their emigrant health care professionals (Sunil 2020).

Again, however, these benefits would need to be weighed carefully against the risks. Although relying on international recruitment seems outwardly popular – with a YouGov poll in August 2022 reporting that 73 per cent of people support recruiting more doctors and nurses from outside the UK (YouGov and The Sunday Times 2022) – Engage Britain’s deliberative work has found that this high level of support wanes slightly as people become more versed in the arguments for and against.

The very real political issues described above would therefore need to be handled. There are ways to do so – the Migration Advisory Committee could be tasked with monitoring the wages of health care professionals to ensure the wages of staff trained in the UK are not being undercut, for example, and further steps could be taken to police the prohibition on the ‘active recruitment’ of staff from countries that the World Health Organization deems to have critical shortages of health care professionals (Department of Health and Social Care 2022a) – but relying on international recruitment is not a politically risk-free option.

Conclusion

This paper has sought to explain the reasons for the NHS's chronic workforce shortages – the difficulties in workforce forecasting, the tendency to undertrain staff in the UK and the insufficiently strategic use of international recruitment – and why they have proven so politically challenging to address.

It has also set out some possible solutions to help politicians overcome these challenges:

- having greater transparency in workforce forecasts
- establishing an independent workforce-planning organisation
- accepting the need for international recruitment.

It bears repeating, however, that none of these solutions is a panacea – and each brings its own challenges. If solving the NHS's workforce shortages was easy, it would have been done by now.

This paper concludes with one final thought, on an issue that by necessity this short paper cannot do justice to.

Technology may force a change in the composition of the health workforce over the next 15 years in ways it has not changed before. It is entirely possible that, in 15 years' time, the NHS will need far more software engineers than it has today, and that it will need relatively fewer doctors and nurses. The likelihood of such a change is difficult to predict, as we have seen, but if it happens then a growing proportion of the NHS workforce will have transferable skills, which would allow them to move between different sectors, and different countries, and the NHS will have to compete for these staff on a more open, global market. The impact of such a change on NHS workforce policy – not least, the current system of collective pay bargaining – is hard to forecast, but is likely to be significant.

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