

The government's Migration Advisory Committee (MAC) has reluctantly recommended that nurses remain on the 'shortage occupation list', while criticising the health sector for failing to maintain a sufficient supply of UK nurses. Sir **David Metcalf**, MAC chair and an active CEP researcher for three decades, summarises the recent report.

A shortage of nurses?

A year ago, the Migration Advisory Committee (MAC) reviewed part of the country's 'shortage occupation list' (SOL). The SOL features job titles and occupations with priority for Tier 2 work visas for skilled migrants from outside the European Economic Area (EEA). Migrants in such jobs do not have to earn the minimum £35,000 pay threshold that is now required to remain in the UK for longer than five years.

The Department of Health did not initially request that nurses be put on the SOL. The MAC assumed, probably erroneously, that the department knows more about the UK labour market for nurses than the MAC does, so did not recommend that they be on the SOL. But during the course of 2015, the department altered its view, and to avoid putting the nation's health at risk, the home secretary added nurses to the SOL in October pending a MAC review.

An occupation must pass three hurdles to be placed on the SOL: is it skilled to the

required level; is it in shortage; and is it sensible to fill vacancies with non-EEA labour? Here, I consider these questions, concluding with some observations about the nursing workforce that require urgent attention from the Department of Health and related bodies.

Skilled, shortage and sensible?

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

In England, there were 361,000 nurses working in the NHS in 2015. But in the UK as a whole – the NHS plus the care and independent health sectors – over 600,000 nurses are employed. The number of nurses has increased in the last three years. The OECD put the proportion of foreign-born nurses in the UK in total employment at 22% in 2011, up from

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15% in 2001. Currently, the corresponding OECD nursing average is 15%. In 2014/15, 8,000 foreign-born nurses were recruited to the UK, mainly from the EEA.

The requisite skill level for inclusion on the SOL is National Qualifications Framework level 6 and above – that is, graduate level. Nurses are skilled to that level.

Evidence from national data and partners indicates that nurses pass five of the seven MAC top-down indicators of shortage. These cover employment, hours worked and vacancies. There are also three pay indicators, but these are not relevant at a time of pay freeze or severe public sector pay restraint.

Guidance from the National Institute for Health and Care Excellence indicates that organisations should aim for a maximum 5% vacancy rate to accommodate operational flexibility needs. Health Education England, the body responsible for workforce planning for the NHS in England, estimates that the current vacancy rate for nurses in England is 9.4%, nearly twice the recommended rate. In London, the Royal College of Nursing puts the rate at 17%. Partner evidence suggests vacancy rates well above 5% in the care sector too.

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

National data and evidence from employers and trade unions therefore suggest a shortage of nurses. But why has this happened?

Demand for nurses

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

- *Population:* the total population is rising, people are living longer and they require more nursing care.
- *Reforms:* moves to integrate the NHS and social care, coupled with an emphasis on seven day working, raise demand.
- *The changing role of nurses:* nurses have taken on more responsibilities, including some duties previously carried out by doctors.

The restraint on nurses' pay is presented as an immutable fact; but it's a choice



The supply of nurses is influenced by workforce planning, training places and retention efforts



■ *The Francis report and staffing guidelines:* demand for nurses rose as trusts sought to increase nurse-to-patient ratios following the 2013 Francis report into events at Mid Staffordshire NHS Foundation Trust.

The supply side

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

■ *Workforce planning:* in England, this involves aggregating local workforce plans into a national plan. The National Audit Office recently commented that this overlooks systemic changes in how services are delivered, and suggested that a more co-ordinated and proactive approach to managing the supply of staff could result in efficiencies for the NHS as a whole.

■ *Training:* between 2009/10 and

2012/13, the volume of commissions (training places for nurses) fell by around a fifth (5,000 places). This trend has been partially reversed recently. The number of places would be substantially higher but for financial pressures.

■ *The move away from bursaries to a student loan system:* in principle this is a sensible policy, but public sector pay restraint may limit the numbers prepared to take up the extra places provided by universities.

■ *Retention:* the turnover of nurses rose from 7.8% in 2008/09 to 9.3% in 2014/15. There is now a noticeable spike in retirements at 55, the earliest age at which a nurse can retire on full NHS pension benefits. Considerable effort is being made to retain nurses. Local initiatives include flexible working, skills development and use of pay supplements.

Pay

Pay is a lever at the disposal of public sector employers to moderate shortages.

If it is not used, the tension in policy objectives between restraining public spending and reducing immigration comes to the fore:

■ Median pay for nurses is £31,500. This is £7,500 below median pay in other graduate occupations.

■ There was a severe shortage of nurses in the late 1990s and early 2000s. The pay review body responded with substantial real pay increases. There is no sign of this happening now, nor of the Department of Health requesting such action.

■ Available pay flexibility is insufficiently used. Possible adjustments include recruitment and retention premia and a market forces factor reflecting cost differences among healthcare providers.

The MAC's analysis shows that there is a historic pattern of peaks and troughs in the supply of migrant nurses. This pattern offers suggestive indications that migrant nurses have been used to save costs. Nursing is an occupation in which migrants earn, on average, less than UK workers doing the same job. In most other graduate occupations, migrants earn on average more than UK workers in the same job.

It is difficult not to see this as undercutting. The evidence shows that non-EEA nurses are typically recruited at the minimum point on the nurses' pay scale. More worryingly, pay at recruitment does not rise with age (an imperfect proxy for experience).

A safety valve

Over the next decade, the shortage of nurses can be addressed by more training places, reduced attrition among trainees, greater efforts at return to practice, more innovative use of pay flexibility and attention to working conditions. In the meantime, it is sensible to add nurses to the SOL.

But there is a problem. The MAC was told by the Department of Health that employers in England will look to recruit around 11,000 non-EEA nurses over the next four years. But including nurses for Northern Ireland, Scotland and Wales, the actual figure could be over 14,000, approaching the annual quota of Tier 2 visas (20,700). Clearly, there is a danger that nurses – with their newly designated priority status – could crowd

out skilled migrants from occupations not in shortage, including engineers and workers in the financial sector.

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

Challenges for the health and social care sector

The MAC recommends placing nurses on the SOL: they are skilled, in shortage and – for a little while – it is sensible to add them. But we make this recommendation with considerable reluctance. It seems to us that the shortage is mostly down to factors that should have been anticipated by the Department of Health and related bodies. Furthermore, there seems to be an automatic presumption that non-EEA skilled migration provides the sector with a ‘get out of jail free’ card. Here, I briefly comment on just four areas: workforce planning; training commissions; pay; and who’s in charge.

Workforce planning

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

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

Health Education England develops its workforce plans by adding together local workforce plans submitted by individual trusts. This means that systemic changes in demand – for example, the drive to

integrate health and social care more effectively – are often not adequately reflected in the workforce plans. In addition, financial pressures in local trusts may lead them to understate their projected workforce needs.

Training commissions

The current shortage of nurses is closely linked to the decision to cut training places in England by more than 17% between 2009/10 and 2012/13. The MAC has been told that this was driven more by financial issues than an expectation that demand would fall. Health Education England has recently confirmed that even now, the 331 additional places that it is funding in 2016/17 fall well below what is actually needed, again due to financial constraints.

Pay

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

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

Who’s in charge?

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

Sir **David Metcalf**, emeritus professor at LSE and a research associate in CEP’s labour markets programme, has been chair of the government’s Migration Advisory Committee since its establishment in 2007.

For further details, see the MAC’s report , published in March 2016 (<https://www.gov.uk/government/news/migration-advisory-committee-mac-report-on-nursing-shortage>).

Nurses could crowd out skilled migrants from occupations not in shortage