

registered nurses.¹³ Outer city trusts have difficulty recruiting nurses in the lowest grades but experience lower turnover in higher grades, such as F and G.

If turnover rates are high (particularly in London), should we be worried? Clearly high turnover has a knock-on effect on staff morale,^{9, 14} organisational finances,^{15, 16} and perhaps patient care.^{17, 18} Little consensus exists over whether there is an appropriate level of turnover that can be applied to all trusts since different, and at times uncontrollable, factors operate in different places and to varying degrees. Consensus is firm, however, among acute trusts in London that turnover rates are too high.

Conclusion

The serious problems facing acute trusts in England in retaining and recruiting nurses result in high financial costs and low morale and may affect patient care. These staffing problems are most stark in inner city and teaching trusts—particularly in London, where they will need to be tackled if the government's modernisation agenda for the NHS is to be realised.

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- 1 Finlayson B, Dixon J, Meadows S, Blair G. Mind the gap: the policy response to the NHS nursing shortage. *BMJ* 2002;325:541-4.
- 2 UK Central Council for Nursing, Midwifery and Health Visiting. *Annual statistics*. Vol 1. London: UKCC, 2000.
- 3 UK Central Council for Nursing, Midwifery and Health Visiting. *UKCC registrants more ethnically diverse than UK population*. London: UKCC press release, 7 February 2001.
- 4 Royal College of Nursing. *Making up the difference: a review of the UK nursing labour market in 2000*. London: RCN, 2000.
- 5 Department of Health. *Statistical bulletin: NHS hospital and community health services non-medical staff in England: 1990-2000*. London: DoH, 2001. (Report No 2001/3.)
- 6 Department of Health. *Vacancies survey, March 2000*. London: DoH, 2001.
- 7 Audit Commission. *Brief encounters: getting the best from temporary nursing staff*. London: AC, 2001.
- 8 UK Central Council for Nursing, Midwifery and Health Visiting. *Big increase in new UK-trained nurses and midwives on national register*. London: UKCC press release, 3 May 2001.
- 9 Meadows S, Levenson R, Baeza J. *The last straw: explaining the NHS nursing shortage*. London: King's Fund, 2000.
- 10 National Audit Office. *Educating and training the future health professional workforce for England*. London: Stationery Office, 2001.
- 11 Smith G, Seccombe I. *Changing times: a survey of registered nurses in 1998*. Brighton: Institute of Employment Studies, 1998.
- 12 Pricewaterhouse. *Nurse retention and recruitment: report on the factors affecting the retention and recruitment of nurses, midwives and health visitors in the NHS*. Bristol: Pricewaterhouse, 1998.
- 13 Seccombe I, Smith G. *Taking part: Registered nurses and the labour market in 1997*. Brighton: Institute for Employment Studies, 1997.
- 14 4 Finlayson B. *Counting smiles: morale and motivation in the NHS*. London: King's Fund, 2002.
- 15 Audit Commission. *Finders keepers: the management of staff turnover in NHS trusts*. Abingdon: AC, 1997.
- 16 Gray A, Phillips V, Normand C. The costs of nursing turnover: evidence from the British national health service. *Health Policy* 1996; 38:117-28.
- 17 Royal College of Nursing. *Snapshot survey of the impact of nurse shortages on patient care*. London: RCN, 1998.
- 18 Department of Health. *National survey of NHS patients: coronary heart disease 1999. National report: summary of key findings*. London: DoH, 2000.

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Mind the gap: the policy response to the NHS nursing shortage

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The British government has launched local and national initiatives to tackle the problems of recruiting and retaining nursing staff. But will these be sufficient to resolve the current crisis?

Difficulties in recruiting and retaining key workers are severely hampering the quality of service the NHS can provide and the progress towards "modernisation." In our other article published in this same issue, we outline the extent of recruitment and retention problems in the nursing and midwifery workforce. Here, we describe the main initiatives for England introduced by the government to tackle the problems and the new administrative machinery to implement them. We discuss whether these initiatives will be adequate.

Government policies

The underlying causes of recruitment and retention can be grouped under four broad headings: pay and the cost of living; the changing nature of the job; feeling valued; and the availability of other employment opportunities.¹ Recent government policies to tackle these problems relate to the first three. We consider the

Summary points

Problems in recruiting and retaining nurses are hampering the "modernisation" of the NHS

Universities are struggling to fill places on nursing diploma and degree courses so are recruiting students from overseas

New NHS workforce development confederations have the potential to resolve recruitment and retention problems but face substantial obstacles

The existing range of national initiatives may not resolve the crisis fast enough

More widespread or radical solutions may need to be considered

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Can the government resolve the housing problems for nurses?

main initiatives outlined in the NHS Plan and the white paper *Improving Working Lives*.^{2 3}

Pay and cost of living

The government has sought to improve nurses' salaries through a series of annual increases and special allowances. From 1 April 2001, nurses received a basic pay increase of 3.7%. Senior nurses (including charge nurses, ward sisters, and nurse specialists), on whom the government was dependent to implement key aspects of the NHS Plan, received a rise of 5%.

Yet nurses' basic pay remains low, even in relation to that of other public sector workers. A newly qualified nurse, for example, begins work on £15 445 (\$23 544; €24 277) (www.doh.gov.uk). By comparison, a qualified teacher begins work on £16 038 or £17 001 depending on level of attainment (www.dfes.gov.uk), and an untrained police officer on £17 133 (www.homeoffice.gov.uk).

In 2001, London nurses also received a 3.7% increase in the London allowance and a cost of living supplement worth up to £1000. Nurses working in high cost areas outside London received up to £600 as a cost of living allowance. The NHS Plan² promised to set up more residential units for nurses—up to 2000 extra in London by 2003—and a central accommodation bureau to match nurses with accommodation. A national housing coordinator was appointed in 2000 to determine the extent of the housing problem for nurses. A new scheme to help nurses and other public sector workers to buy their first home was announced in September 2001.⁴

But living costs remain a concern, particularly in London. At the end of June 2001, the average house price in Greater London for April to June 2001 was £205 831.⁵ For the same period, the average price in Kent was £128 001, in the West Midlands £82 480, and in Greater Manchester £69 358. On the basis of a typical mortgage allowance of three and a half times salary, a staff nurse on a salary at the top of grade E (£19 935) (www.doh.gov.uk) could borrow only about £69 772 towards a property. A nurse living in London would therefore have to earn £60 000 to afford the same house as a nurse living in Greater Manchester.

Changing nature of job

Increasing bureaucracy with lack of appropriate support

Nurses have experienced an increase in paperwork in recent years, partly as a result of regular audit and

clinical governance activities. Like other professionals working in the NHS, nurses complain they do not have good administrative support and work overtime as a result.⁶ Efforts by the Regulatory Impact Unit at the Department of Health to limit paperwork for general practitioners have not been replicated for nurses.

Limitations to clinical roles and lack of senior clinical posts

More opportunities to expand nurses' clinical roles are being developed. The NHS Plan proposed to extend nurses' prescribing rights, allow nurses to make and receive referrals, and admit and discharge patients.² The NHS Plan also championed the need to consider new ways of working. The Changing Workforce Programme was subsequently set up by the Department of Health to assess different ways of doing this.⁷

Historically, senior clinical roles for nurses have been lacking. In 1999 the government reiterated its commitment to a "modern career framework" for nurses, which incorporated the creation of consultant posts for nurses, midwives, and health visitors.⁸ The NHS has only 500 nurse consultant posts, however, and a doubling of this figure by 2004, as promised by the NHS, may be insufficient given the overall size of the nursing and midwifery workforce. The NHS Plan also promised to "bring back Matron," but it is unclear how many of these posts will be available.

Caring for more patients with fewer staff

High levels of vacancies and turnover in nursing staff in trusts mean that existing staff have increased workloads and supervise agency staff who are often unfamiliar with the wards.⁹ Cutbacks in staff costs are resulting in nurses having to care for more, and more acutely ill, patients with fewer staff.⁹ Evidence from the United States, Canada, and Germany found that nurses were spending time performing functions not related to their professional skills, such as cleaning rooms or moving food trays. Nurses also reported more pressure to take up management responsibility, taking them away from direct patient care.¹⁰

To reduce some of these pressures, the government promised to recruit an extra 20 000 nurses (not including healthcare assistants) to the NHS by 2004.² These headcount numbers (notably not whole time equivalents, which lowers the potential contribution to the NHS) were to be met through attracting back nurses who had left the NHS ("returners"), recruiting trained nurses from overseas, and increasing the number of training places in nursing and midwifery. Two high profile recruitment drives—in 1999 and 2000—yielded 6000 and 5797 returners respectively by September 2000,¹¹ although areas with the highest vacancy rates, such as London, received a disproportionately low share of these nurses.¹² A third high profile campaign, in 2001, recruited 713 returners between April and July 2001.¹³

The Royal College of Nursing suggests, however, that the current number of vacancies for nurses is around 22 000 whole time equivalents. The college calculates that if retirement levels and other losses remain the same, the NHS will need to recruit 110 000 nurses by 2004—less than half of which will be met through training.¹²

In the NHS Plan, the government pledged year-on-year increases in training places for nurses, midwives, and health visitors so that by 2004 the number of places would be increasing by 5500 a year. However, many universities are struggling to fill places on nursing diploma and degree courses and are recruiting students from overseas to plug the gaps. At South Bank University in London, for example, 30% of current nursing students are not European nationals.¹⁴ There is a discrepancy, however, between these and the official figures from the Higher Education Statistics Authority, which suggest overseas students at South Bank University comprise only 7.6%. The reason for this discrepancy could be the way in which data on students' domicile are compiled. None the less, if this example is true of other universities, it may indicate that the NHS is funding a substantial number of places for overseas students who may be less likely to work in the NHS after qualifying.

Feeling valued

Many of the new initiatives outlined above, such as recognising the importance of ongoing staff development, may help to make nurses feel more valued in their work. So too may the efforts to encourage flexible and family friendly work arrangements, outlined in a 1998 government white paper¹⁵ and reiterated in the NHS Plan.² The table shows examples of some of the challenging targets that NHS trusts have been asked to meet. NHS trusts will be held to account for progress against these performance indicators, and the level of progress will be linked to their financial resources.

Racism and violence in the workplace also undermine esteem.⁹ The government has adopted a zero tolerance policy on violence against staff and is committed to eradicating harassment and discrimination in the NHS. Both of these issues are included in the Department of Health's *Improving Working Lives Standard*, which NHS employers are expected to meet by April 2003.¹⁶

But politicians are sending out mixed messages. On one hand they champion nurses—for example, by setting up the health and social care awards in 1998 to recognise the achievements of staff. On the other hand, the government rhetoric on public service workers can be negative. These mixed messages could undermine hard pressed workers further.

New administrative machinery

To help translate national policies on workforce into action on the ground and encourage delivery, the government has tried to strengthen the administrative machinery.

Nationally

After the launch of the NHS Plan, a series of taskforces were set up to help implement its proposals in key priority areas, such as the workforce and clinical priorities (for example, cancer and coronary heart disease). The national Workforce Taskforce, together with local modernisation boards (responsible for implementing the NHS Plan locally), are charged with encouraging and assessing local progress against targets. Both the Workforce Taskforce and the local modernisation boards are ultimately accountable to the NHS

Modernisation Board, which is responsible for overseeing the NHS Plan's implementation nationally. The taskforces have no set life span.

Locally

The government also announced proposals in the NHS Plan to replace the education and training consortiums with new NHS workforce and development confederations. The 39 consortiums were established in England in 1996 and charged with determining the number of non-medical (such as nursing, physiotherapy, occupational therapy) training places required, commissioning those places, and monitoring the resulting contracts with, for example, education providers.¹⁷ The 24 new confederations were set up on 1 April 2001. Their role is similar to the consortiums', except their scope is larger, most notably managing and commissioning education and training for all health professionals in their patch. Initially, the postgraduate deaneries will retain responsibility for funds for medical education and training, but the confederations are intended to absorb this role in future.

Whereas the consortiums comprised a group of representatives from different stakeholders who came together for specific meetings, the new confederations have a more formal corporate structure. Each has a full time chief executive and a chair, and an initial annual budget of about £150m. The confederations are not independent statutory bodies but, unlike the consortiums, have clear lines of accountability to the regional director of workforce development.¹⁸

Local stakeholders are represented on confederation boards. Stakeholders include representatives from health authorities, NHS trusts, and primary care trusts; postgraduate deans; and representatives from primary care education, higher education institutions, medical schools, local authorities (social services), the voluntary and independent sectors, and the prison service. Through working with these bodies, and holding the budget for training, the confederations should be able to influence NHS employers in their patch on matters such as recruitment and retention, accommodation for staff, continuing professional development, flexible working opportunities, and leadership programmes.

With a strengthened corporate structure, clearer lines of accountability, explicit targets to meet, a wider reach across the workforce, and a larger budget, the confederations have the potential to make more progress in tackling recruitment and retention problems than their predecessors. But they will also need to overcome considerable obstacles. These include a lack of adequate data on workforce on which to plan; the robustness of trusts' workforce predictions and how these link to the delivery of health improvement programmes; a historical lack of engage-

Targets in staffing and training for NHS employers. Data from Department of Health^{2 16}

Target	Date to be reached
Training and development plans for most health professionals	April 2000
Annual workforce plan	April 2000
Occupational health services and counselling available for all staff	April 2000
Commitment to flexible working arrangements*	April 2003
Childcare coordinator to liaise with staff and childcare providers	2003

*For example, flexible working hours.

ment of chief executives in workforce development; and, more fundamentally, the fact that NHS workforce issues are still not high enough on the agendas of many NHS employers.

Conclusion

The government has acknowledged and sought to tackle the serious problems of recruiting and retaining nurses. But despite the resulting national initiatives, problems persist. Overall progress has been slow; staff are unaware of the new opportunities available to them⁶; some targets are modest, such as plans for 100 trusts to have onsite nurseries by 2004; little effort has been made to evaluate the impact of these initiatives. Workforce issues are still nowhere near the top of the agenda for managers or trust boards, who have other managerial “must do’s,” such as reducing waiting lists and times, managing emergency admissions, and breaking even financially. The new confederations have great potential to shape the agenda, but they are still in their infancy.

Will the national initiatives, if fully implemented on time, actually deliver? They will help, but it is questionable whether they will turn the tide. In the meantime more radical suggestions for a complete redesign of the healthcare workforce are being proposed, both as a way of designing a more patient focused health system and as an alternative strategy to tackle problems of recruitment and retention. The merits of these proposals should be openly debated and their evidence base evaluated.

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- 1 Finlayson B, Dixon J, Meadows S, Blair G. Mind the gap: the extent of the NHS nursing shortage. *BMJ* 2002;325:538-41.
- 2 Department of Health. *The NHS plan: a plan for investment, a plan for reform*. Norwich: Stationery Office, 2000.
- 3 Department of Health. *Improving working lives in the NHS*. London: DoH, 1999.
- 4 Department for Transport, Local Government, and the Regions. *Nurses, teachers and police get government help to buy homes in housing hotspots*. Press release, 6 September 2001.
- 5 Collis P. *HM land registry residential property price report: April to June 2001 compared with the same period in 2000*. London: Land Registry, 2001.
- 6 Smith G, Seccombe I. *Changing times: a survey of registered nurses in 1998*. Brighton: Institute for Employment Studies, 1998.
- 7 Changing Workforce Programme. *Briefing paper*. London: Department of Health, 2001.
- 8 Department of Health. *Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. London: DoH, 1999.
- 9 Meadows S, Levenson R, Baeza J. *The last straw: explaining the NHS nursing shortage*. London: King's Fund, 2000.
- 10 Aiken L, Clarke S, Sloane D, Sochalski J, Busse R, Clarke H, et al. Nurses' reports on hospital care in five countries. *Health Affairs* 2001;20:43-53.
- 11 NHS Executive. *Recruiting and retaining nurses, midwives and health visitors in the NHS—a progress report*. London: Department of Health, 2000.
- 12 Royal College of Nursing. *Making up the difference: A review of the UK nursing labour market in 2000*. London: RCN, 2000.
- 13 Department of Health. *Milburn: we are delivering on pledge to bring in more nurses*. Press release, 13 July 2001.
- 14 Duffin C. Universities fear drop in foreign student numbers. *Nursing Standard* 2001;15:4.
- 15 Department of Health. *Working together: securing a quality workforce for the NHS*. London: DoH, 1998.
- 16 Department of Health. *Improving working lives standard: NHS employers committed to improving the working lives of people who work in the NHS*. London: DoH, 2000.
- 17 Buchan J, Seccombe I, Smith G. *Nurses work: an analysis of the UK Nursing Labour Market*. Aldershot: Ashgate, 1998.
- 18 Department of Health. *Workforce Development Confederations guidance: functions of a mature confederation*. London: DoH, 2001.

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Holidays in Framingham?

It was a wet evening in May. We were driving into Boston from New Hampshire without definite plans on where to stay for the night. Suddenly a large motorway road sign loomed out of the mist: Route 9 West—Framingham. “I know that name,” I said, “Let’s stay there: it would be interesting to see what sort of people are in the Framingham study, and what they eat.” So my wife and daughter agreed with my idea, for once.

It took some time, on a series of interconnecting highways, and when we finally got there, on Route 9, we had difficulty in identifying the town at all. Route 9 bisects it and consists of a continuous series of road signs and large warehouses. When we finally retraced our route and got off the highway we found Framingham to be a curious place. One part was a New England wooded village with a white painted church and prosperous housing. Another long main street across the highway was populated by lawyers and funeral parlours. Eventually we found the city centre, with a fine central memorial hall. But nowhere to stay—the inhabitants seemed to speak Spanish, and even food was difficult to find. Eventually we found the only hotel, back on Route 9, where the only restaurant provided a massive Mexican style meal.

Framingham was selected for the study of the epidemiology of atherosclerotic disease in 1951 when

it was “a small self-contained community of approximately 28,000 inhabitants, 18 miles west of Boston.” I wonder about the subsequent lifestyle and eating habits of all those people who have been part of the Framingham study. How many of them were part of the old New England village way of life; how many lived precariously on the edge of Route 9; were any of them Spanish speaking, Mexican food eating immigrants? Their epidemiological experience in the United States has played a major part in producing the cardiovascular guidelines for Britain, but I suspect the present inhabitants will have different risks.

As a holiday stopover, it might not score highly, but it was an interesting experience.

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for “Endpieces,” consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.