

*Staffing matters;  
funding counts –*  
**Supplement:  
Workforce profile  
and trends**

The workforce of the NHS in England:  
current profile and recent trends

## **About this supplement**

This supplement is produced to accompany the report *Staffing matters; funding counts: An analysis of workforce profile and trends in the English NHS*.

This supplement briefly describes the current profile and recent trends in the NHS workforce in England. The aim is to set out salient characteristics of national policy concern, and to set the scene for more detailed examination of 'pressure points' for national workforce policy (see [www.health.org.uk/publication/staffing-matters-funding-counts](http://www.health.org.uk/publication/staffing-matters-funding-counts) for further supplements on specific pressure points).

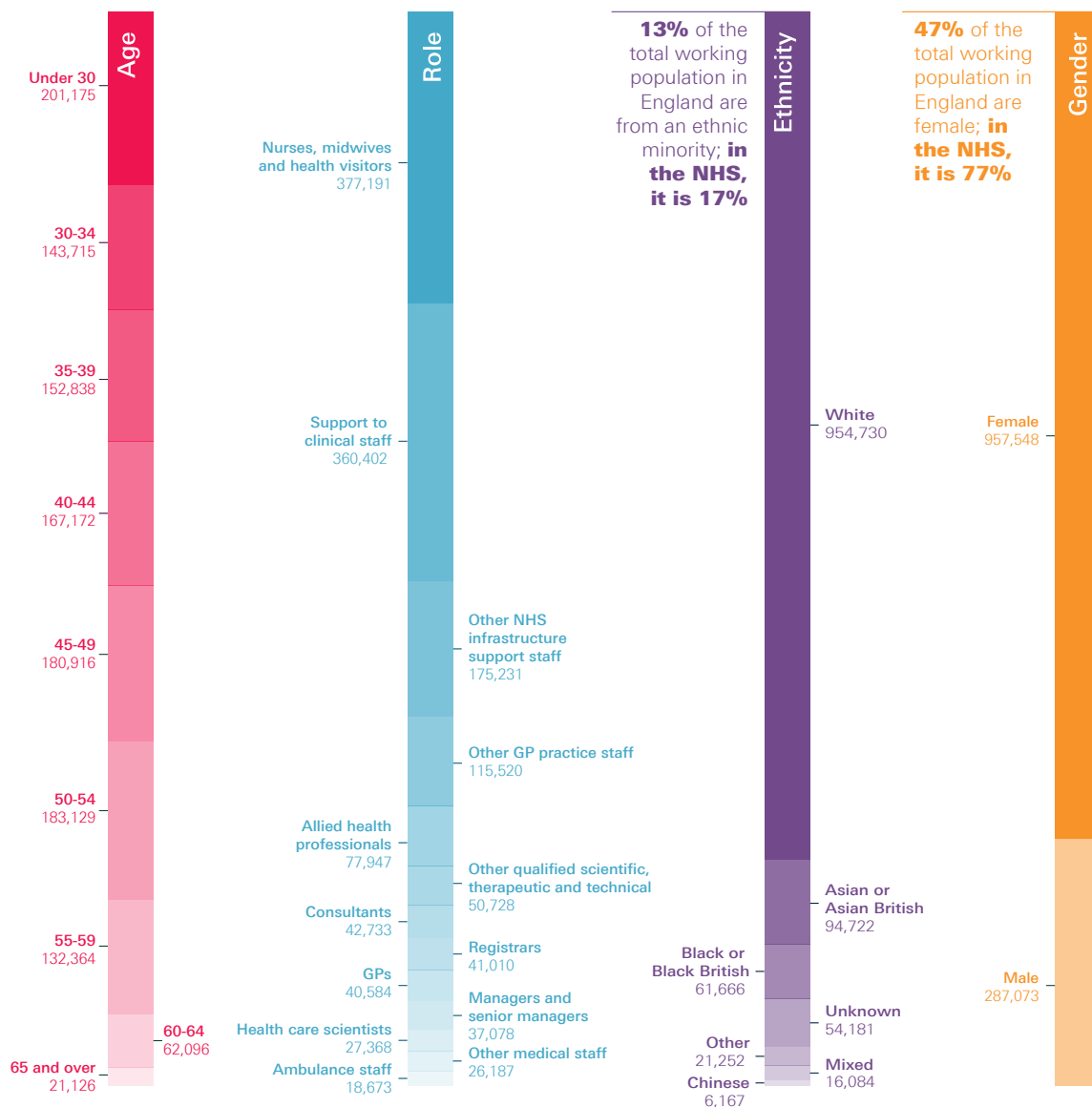
While the focus is on England, some of the national/international data sets are at UK level. Where UK data is reported, it should be remembered that the NHS in England is by far the largest component, employing approximately four in every five NHS staff in the UK.

# The workforce of the NHS in England: current profile and recent trends

## More than a million

Figure A below summarises some of the components of the overall workforce in the NHS and related GP services. Well over one million people are employed in these services, with the main blocs being qualified nursing, midwifery and health visiting; support staff in clinical services; and 'infrastructure support (administrative, clerical, managerial staff).

Figure A: The size, scale and diversity of the NHS workforce<sup>1</sup>



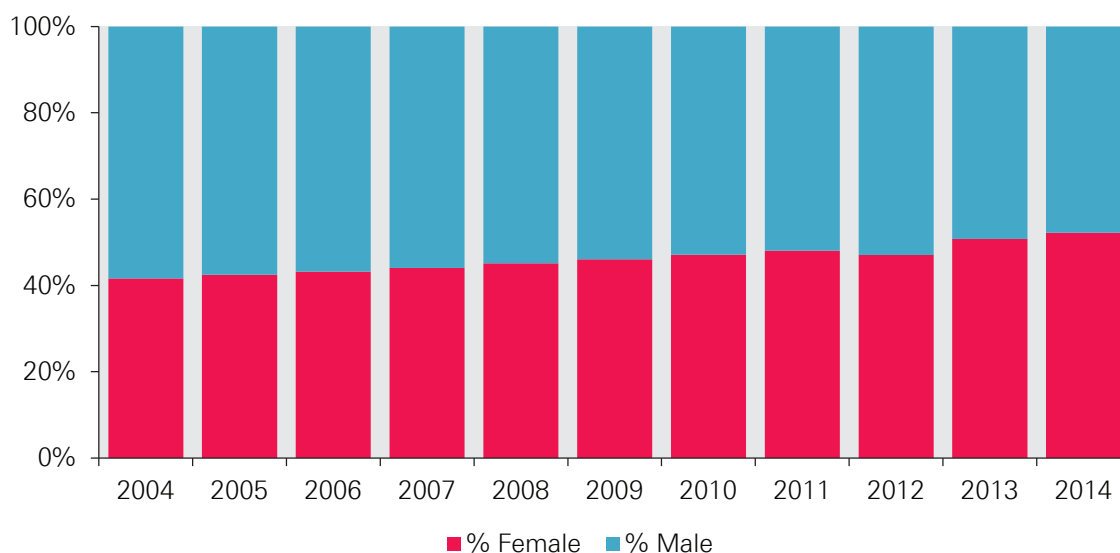
Source: HSCIC. *NHS Workforce: Summary of staff in the NHS*. HSCIC, 2014. [www.hscic.gov.uk/catalogue/PUB16933/nhs-staf-2004-2014-over-rep.pdf](http://www.hscic.gov.uk/catalogue/PUB16933/nhs-staf-2004-2014-over-rep.pdf)

Please note: Age, gender and ethnicity figures exclude 144,126 GP registrars and other GP staff for whom we do not have age and gender information. We also do not have ethnicity data for GP practices at all, therefore the totals will not add up. Role totals do not sum to NHS staff total due to HSCIC figures.

## Gender change in some professions, not all

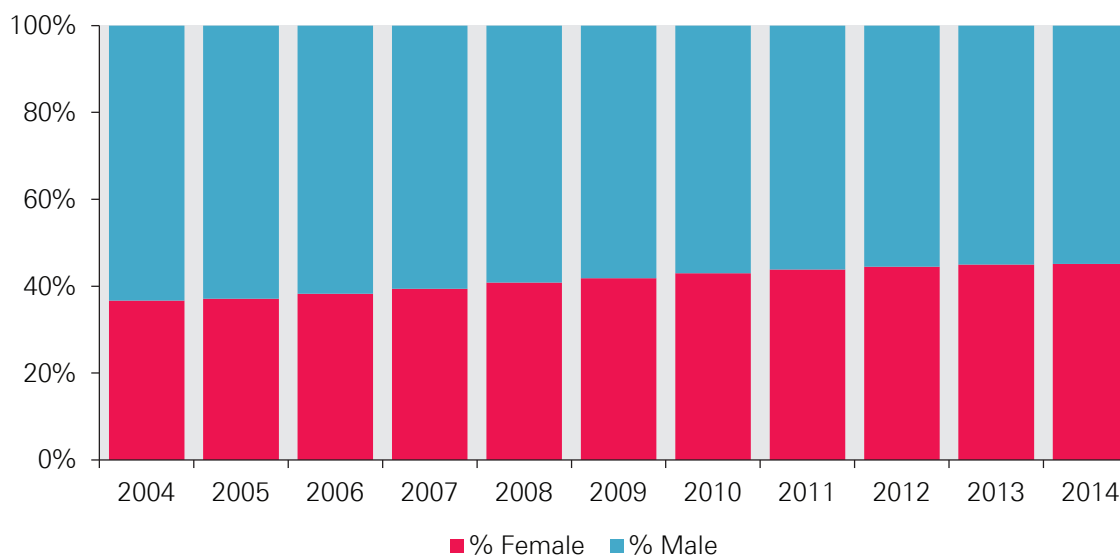
The health sector is a major employer of women, but some professions remain gender segmented. While the proportion of women working as GPs and hospital and community health service (HCHS) doctors has been increasing slowly (figures B and C), the percentage of nurses who are men has remained around the 10% mark (figure D)

**Figure B: Percentage of GPs (headcounts) by gender, 2004–14**



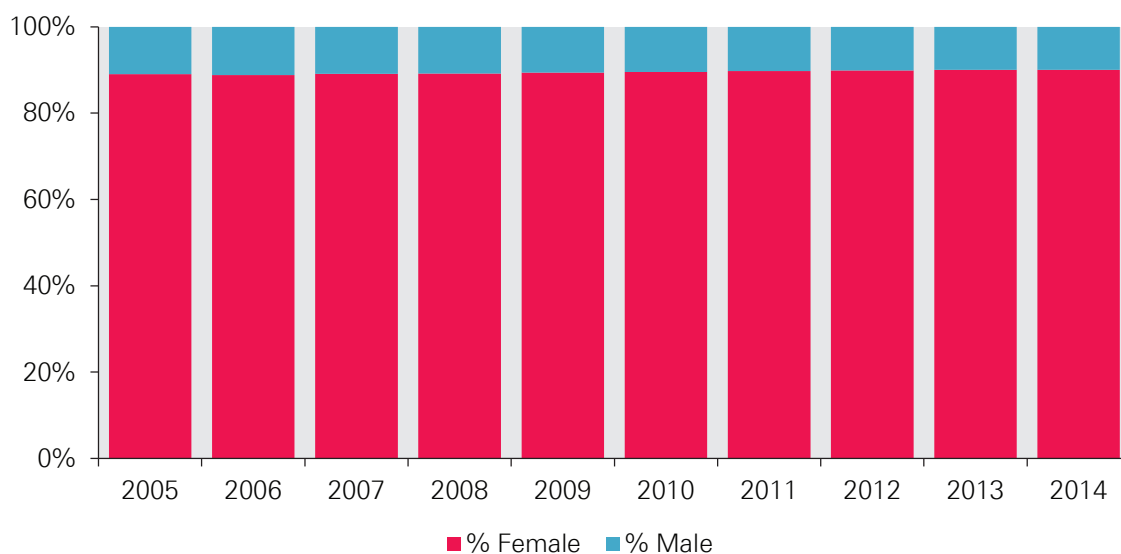
Source: HSCIC, 2004 to 2014 general practice.

**Figure C: Percentage of HCHS doctors (headcounts) by gender, 2004–14**



Source: HSCIC, 2004 to 2014 medical staff and dentists.

**Figure D: Percentage of qualified nurses, midwives and health visitors (headcounts) by gender, 2005–14**

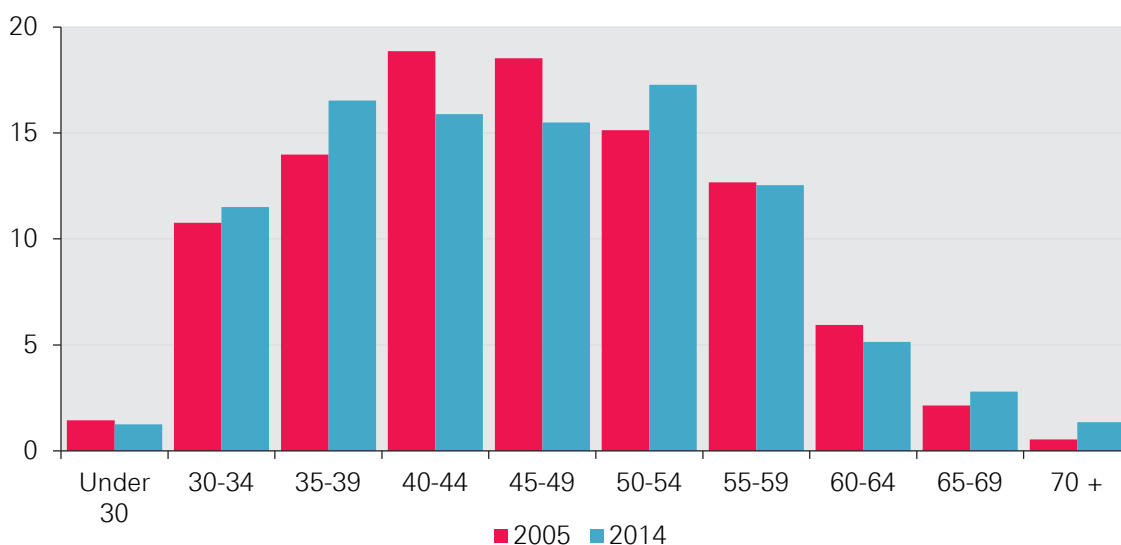


Source: HSCIC, 2004 to 2014 non-medical staff.

## (Some) ageing professions

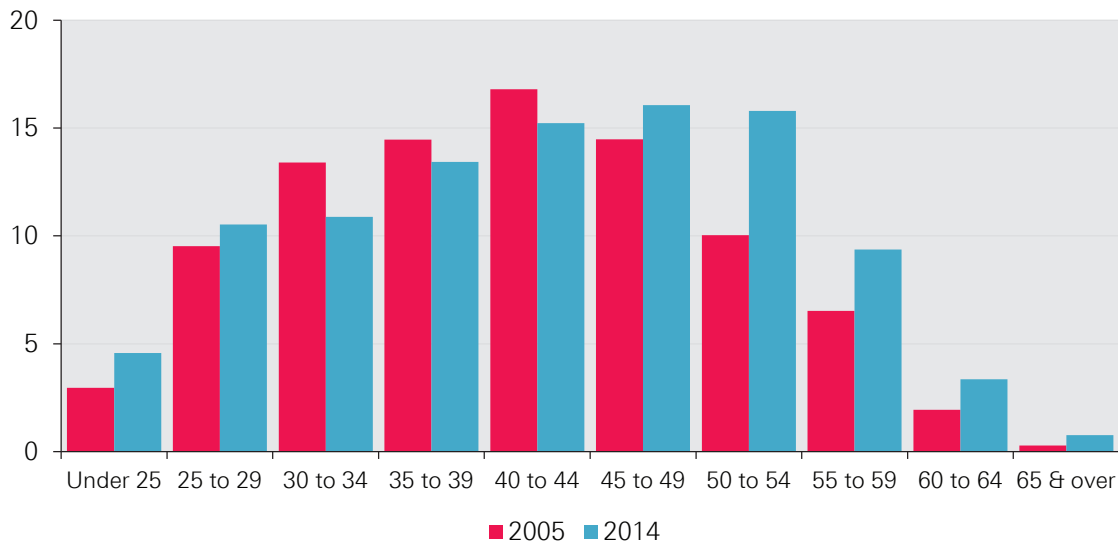
Age profile is an important indicator of likely labour market behaviour and potential retirement patterns. Some parts of the NHS workforce – notably qualified nursing staff, nursing support staff, and GPs – have an ageing profile, which flags policy concern. For example, one in five GPs is aged 55 or older (figure E) and almost one in three qualified nurses, midwives and health visitors is aged 50 or older (figure F). Both of these occupational groups are facing likely significant growth in retirements over the next 5–10 years.

**Figure E: Percentage of GPs (headcounts) by age group, 2005 and 2014**



Source: HSCIC, 2004 to 2014 general practice.

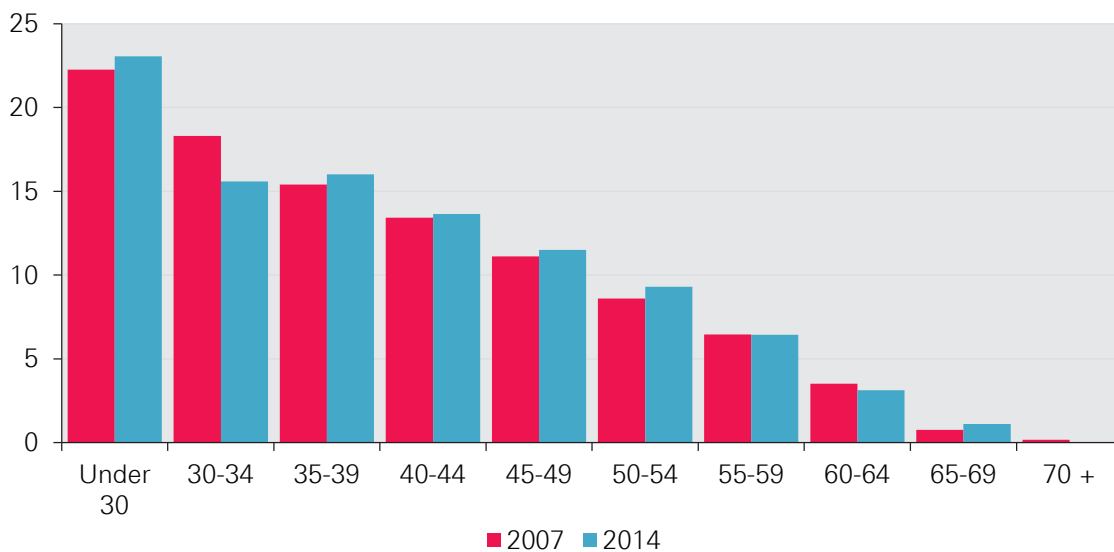
**Figure F: Percentage of qualified nurses, midwives and health visitors (headcounts) by age group, 2005 and 2014**



Source: HSCIC, 2004 to 2014 non-medical staff.

Other groups such as allied health professionals and HCCHS doctors (figure G) have a younger profile, which suggests less immediate policy concern about overall retirement patterns and reflects relatively large recent intakes to the profession. Organisation for Economic Co-operation and Development (OECD) data highlight that the UK has the lowest proportion of doctors aged 55 or older of any OECD country, at 13%. This compares with an OECD average of 33%.<sup>2</sup>

**Figure G: Percentage of HCCHS doctors (headcounts) by age group, 2007 and 2014**

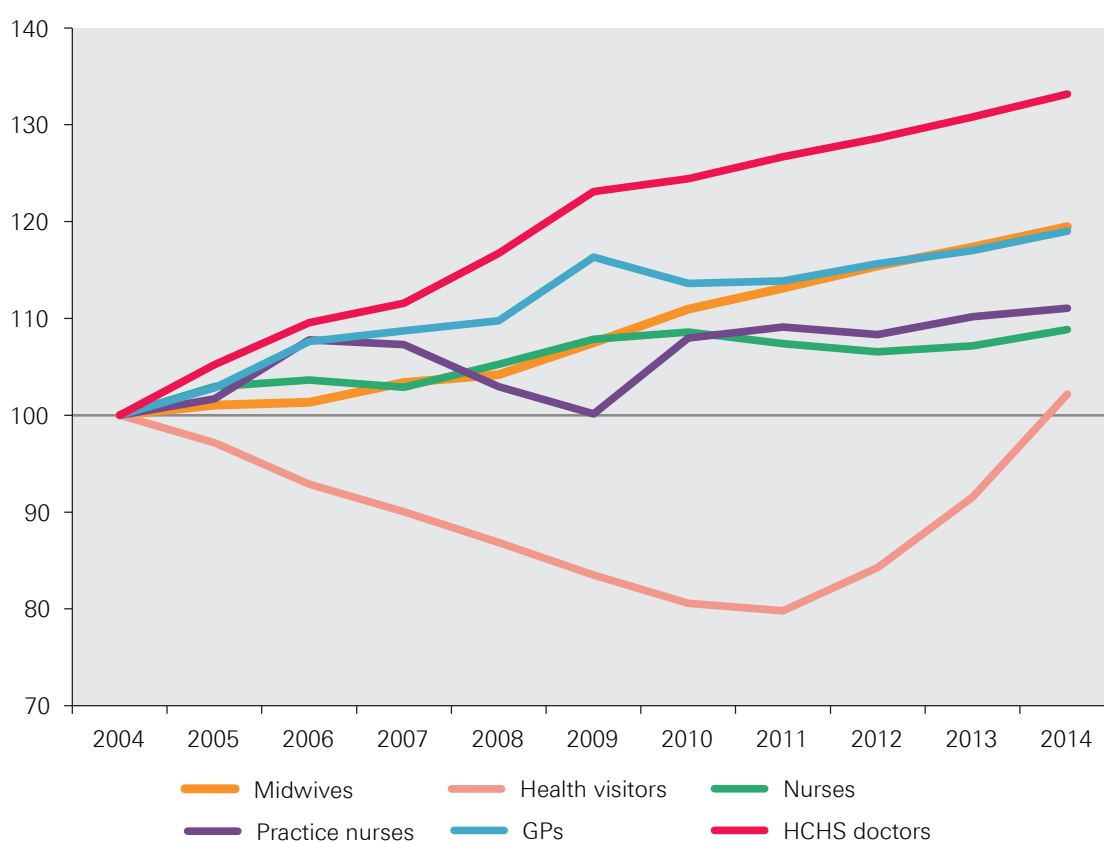


Source: HSCIC, 2004 to 2014 medical staff and dentists.

## More doctors, more nurses, fewer managers

There have been marked variations in growth in different professions and groups in NHS England across the period 2004–14 (figure H). The largest growth has been in the HCHS doctor workforce, which is about one third larger than 10 years ago; the GP workforce has also grown, by 19%. The qualified nursing workforce and qualified midwifery workforce has exhibited a lower rate of growth, and this growth has tailed off in more recent years. The nursing workforce growth was about 9%. The relatively small number of health visitors was in decline in the early part of the period, but received specific national policy attention and associated funding in 2010, and subsequently grew significantly. Managers (not shown), have actually reduced in number by a few percentage points.

**Figure H: Change in selected occupations, NHS in England, 2004–14 (FTE)**

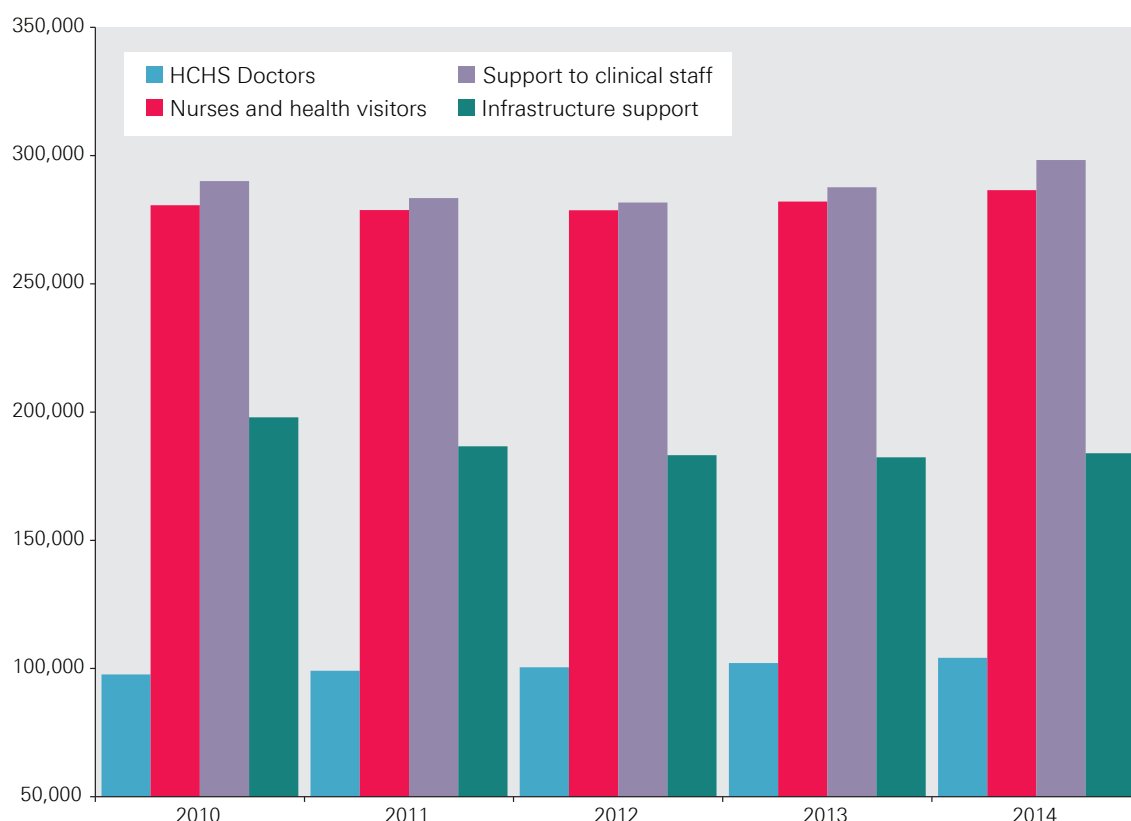


**Note:** There were changes to the data collection system between 2006 and 2009 particularly for GPs. Since 2010 the GP data collection process has changed by collecting information at individual practice level rather than at an aggregate PCT level, which makes the figures from 2010 onwards not fully comparable with previous years.

Source: HSCIC. *NHS Workforce Statistics in England, Summary of staff in the NHS - 2004-2014, Overview*

More recent data from 2015 is listed as ‘experimental’ by the NHS Health and Social Care Information Centre and is not directly comparable with the trend data for 2004–14. However this most recent (headcount) data shows an actual decline in the number of GPs for 2014/15. The years since 2010 have been marked by funding austerity, and the impact of this is reflected in changes to staff patterns (figure I). While the number of HCHS doctors employed in the NHS increased, the number of infrastructure support staff fell on a sustained basis. The number of full time equivalent (FTE) nurses and clinical support staff both fell at the start of the decade but this proved to be unsustainable and numbers have increased since 2013.

**Figure I: Number of nurses employed in acute, general and elderly sectors, excluding bank and agency staff, 2010–14**



Source: HSCIC. *NHS Workforce Statistics in England, Summary of staff in the NHS - 2004-2014, Overview.*

The variable levels of staffing change in recent years have also contributed to changes in staffing patterns and grade mix in different NHS sectors.

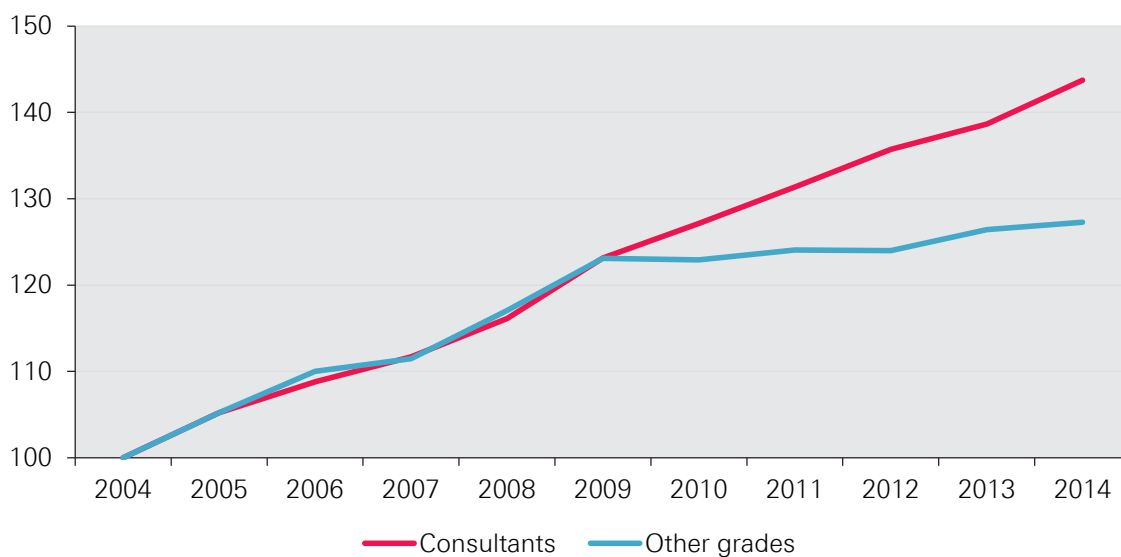
For example, in the medical workforce, while the number of doctors working in NHS hospital and community medical services has increased by nearly a third (to 104,500 FTE), representing around 2.95% a year over the past decade. Growth in the number of GPs has been slower at 1.8% (36,920 FTE) – a rise of 19% over the period.



Another example is community and primary care, which has seen lower nursing workforce growth than in the hospital sector, despite being regarded as a NHS policy priority area. The number (FTE) of first-level qualified nurses and midwives working in NHS hospital services (acute, elderly, general, maternity and paediatrics) has risen from 154,371 in 2004 to 177,255 in 2014, which is an increase of 14,084, or 8.6%. In contrast the number of district nurses, health visitors and other first-level qualified nurses working in community nursing has only increased by 2,415 (to 42,771 in 2014) – a rise of 6%.

Grade mix changes have also occurred. For example, the number of professionally qualified medical staff working in hospital and community health services in England has grown by just under 8,000 to 104,400 over the past 10 years. At the same time, figure J shows there has also been a significant shift in the grade mix. During the first half of this period numbers of consultants and other grades grew at very similar rates, roughly 5% a year, but since 2009 the growth rates diverged with other grades, increasing by 1% or less. As a result, consultant numbers stood at just over 43,000 (FTE) in January 2016, accounting for 39% of the total (compared with 36% in 2004).

**Figure J: Change in hospital consultant and other grades, NHS England, 2004/05–2014/15 (2004/05=100)**



Source: HSCIC (March 2016) NHS Workforce Statistics, Sept 2015 England, experimental.

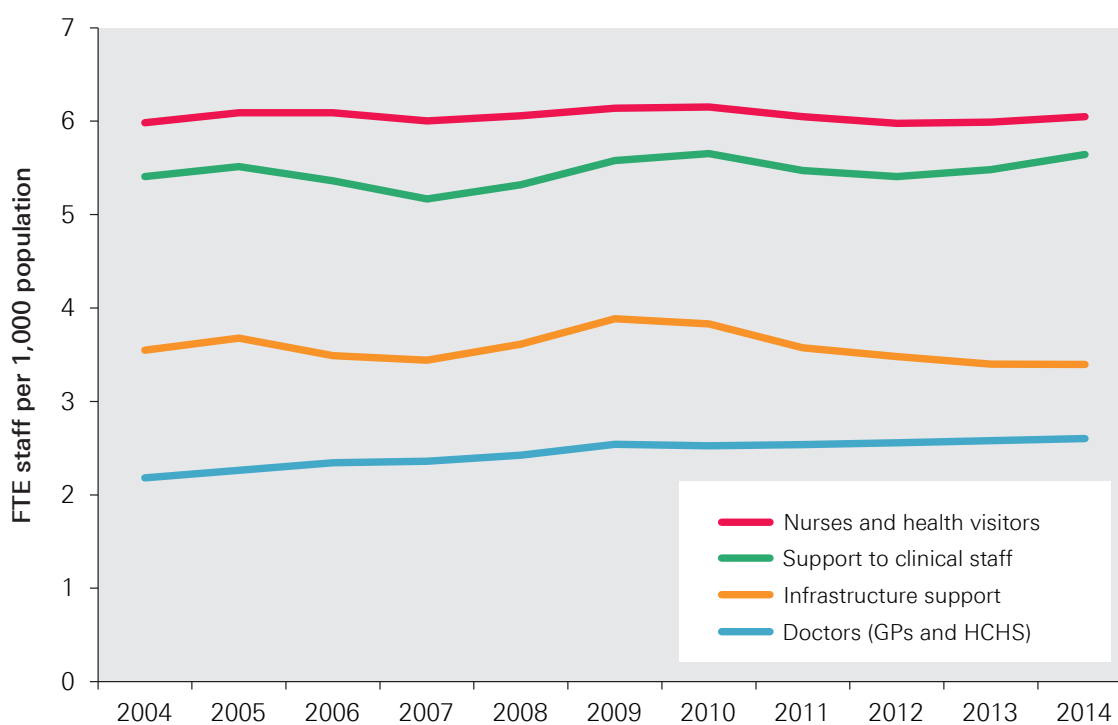
This grade mix change is the result of rapid increases in the numbers of doctors being trained in the early 2000s, and policy changes to alter the medical career structure with the objective of creating more consultant grades.<sup>3</sup>

## ...But increases in workload outstrip more modest staffing change

How much is enough? This is not a question easily answered in the context of NHS staffing. At national level, available data allows some comparisons across time which give some insight to changing trends of staffing in relation to loose measures of activity or ‘demand’.

Data on the staff:population ratio for key groups in NHS England (see figure K) show a slight downward trend in nurse:population ratios in recent years, and a slight increase in doctor:population ratios. This reflects the variable pattern in staffing growth highlighted earlier, with more consistent growth in doctor numbers, and a much more modest increase in qualified nurses in the period 2004–14.

**Figure K: Staff:population ratios, 2004–14**

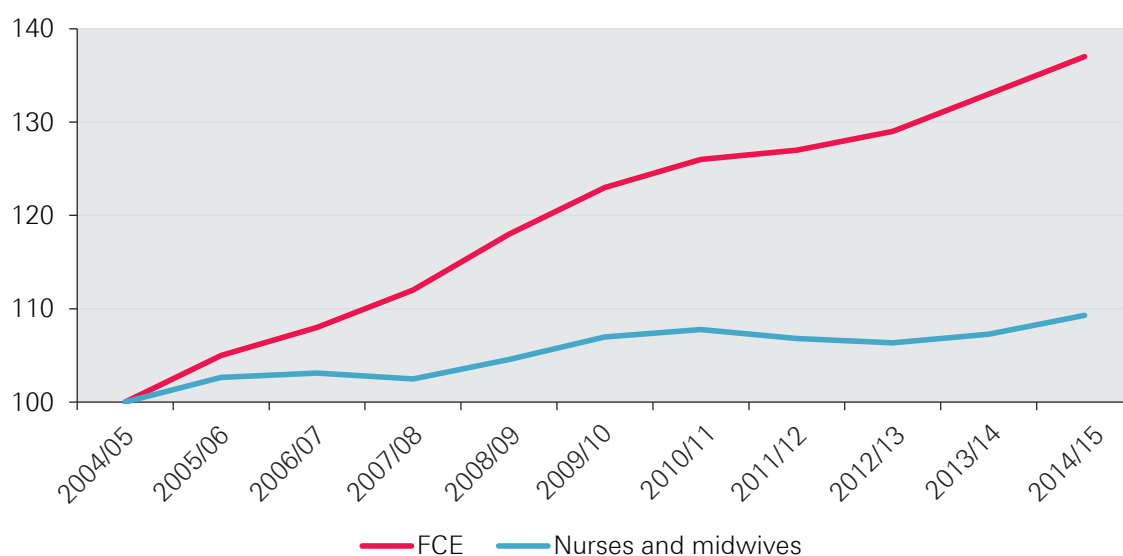


Source: HSCIC. *NHS Workforce Statistics in England, Summary of staff in the NHS - 2004-2014, Overview*.

Comparing NHS England with the other three UK countries is problematic because of differences in statistics and in definitions of who is included (and excluded) in NHS numbers. However, previous analysis of nurse:population ratios across the UK by the Health Foundation found England to have much lower rates (5.8 per 1,000 population) in 2011 than the other UK countries (Wales 7.1, Northern Ireland 7.5, Scotland 7.9).<sup>1</sup>

Another broad measure of change is to compare staffing change across time with the basic indicator of NHS activity: finished consultant episodes (FCEs). Figure L shows the trend in qualified nursing and midwifery numbers since 2004–05 in comparison to FCE change. There has been rapid and continuous growth in FCE across the period since 2004–14; in comparison, as noted earlier in the report, nursing numbers have grown more slowly in recent years.

**Figure L: Qualified nursing and midwifery staff and finished consultant episodes, NHS England, 2004/05–2014/15**



Source: NHS HCHS (November 2015), Hospital Episode Statistics, Admitted Patient Care, England, 2014-15.

NHS activity, as measured by FCEs has continued to grow over the past 10 years, rising from 13.7m in 2004/05 to 18.8m in 2014/15. Over the same period, mean length of patient stay has fallen from 7.1 to 5.0 days. In other words, more patients are being treated, more quickly, in acute hospital services. But, with patients on the wards for a shorter period of time, the average level of patient acuity is also higher, requiring more intense care. Overall, this suggests that workloads for nursing staff in acute care have continued to grow as staffing growth has slowed.

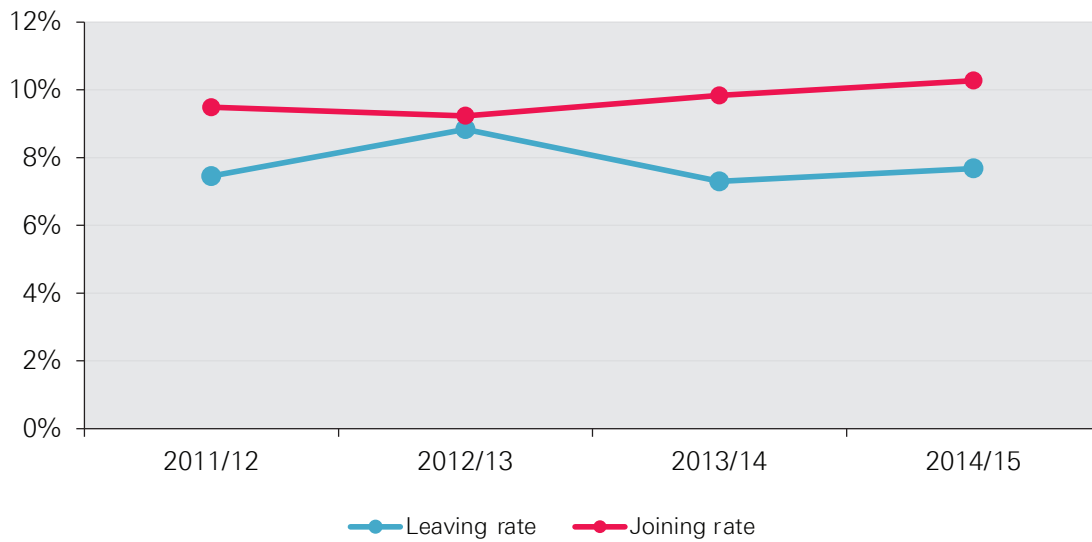
In GP-led services there has also been a situation of increased workload outstripping more modest growth in staffing. A King's Fund survey covering the period 2010/11–2014/15 reported that 'GP workload has grown hugely, both in volume and complexity. The research sample shows a 15% overall increase in contacts: a 13% increase in face-to-face contacts and a 63% increase in telephone contacts'.<sup>4</sup> Over the same period, the GP workforce grew by 4.75% and the practice nurse workforce by 2.85%.

## More joiners... and leavers

In recent years, data have been published on the annual turnover rates of main NHS occupations. This information on 'joiners' and 'leavers' assists in assessing the dynamics of the workforce.\* Figure M shows annual rates for HCHS doctors, with about a 10% annual joining rate and an 8% annual leaving rate, reflecting the overall growth in the hospital doctors workforce.

\* The leaver/joiner rate is calculated by dividing the number of leavers/joiners by the average of the headcount of staff at the beginning of the period and headcount of staff at the end of the period.

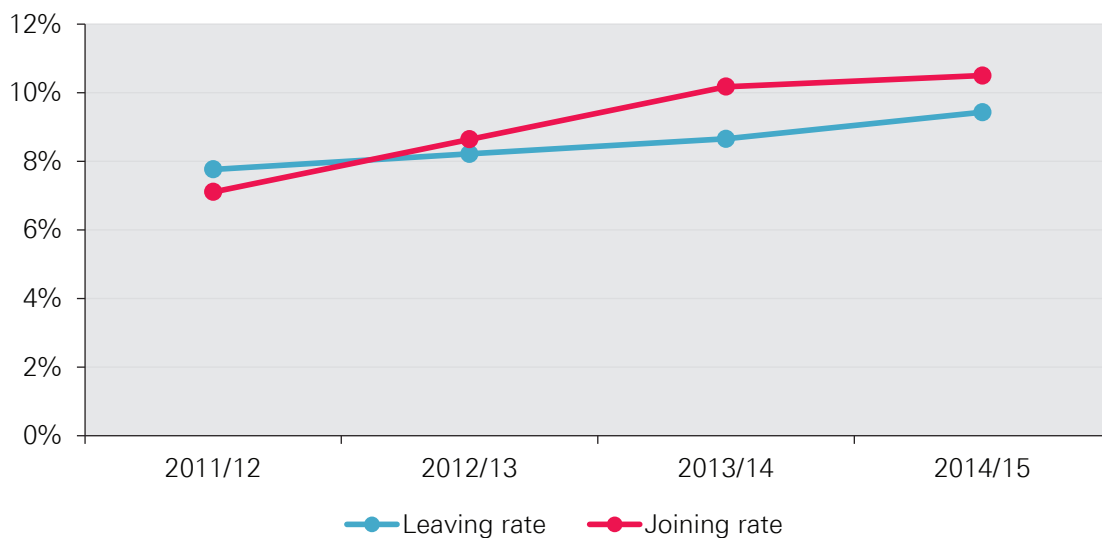
**Figure M: Annual rate of HCCHS doctors joining and leaving the workforce, 2011–15**



Source: Provisional statistics Sept 2011-2012; Sept 2012-2013; Sept 2013-2014.

For nurses, there is a more pronounced increase both in annual joining rates and leaving rates across the period since 2011/12 (figure N), which had increased from about 8% per annum to nearly 10% in 2014/15.

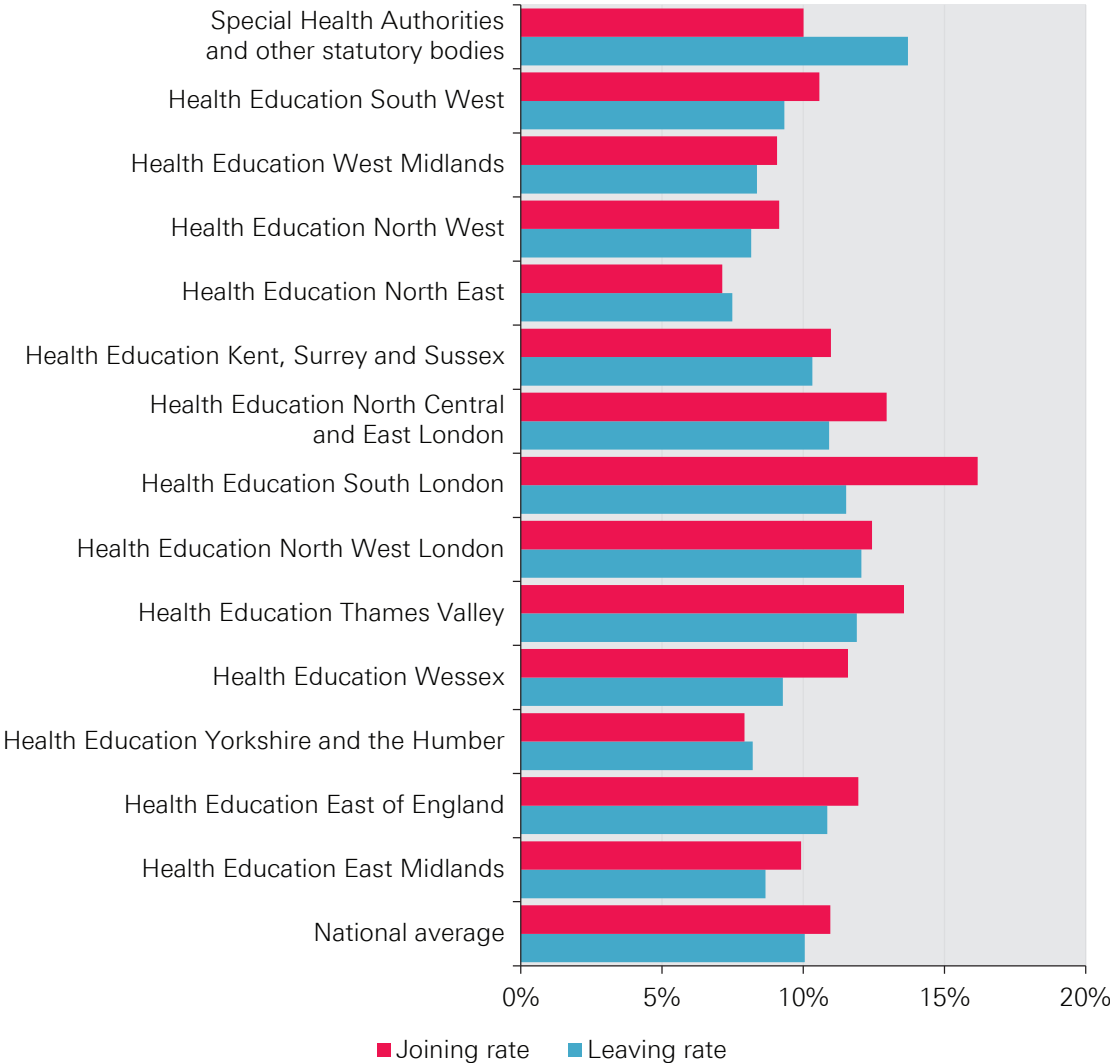
**Figure N: Annual rate of qualified nurses, midwives and health visitors joining and leaving the workforce, 2011-2015**



Source: Provisional monthly NHS workforce statistics Sept 2012-13; Sept 2013-14; Sept 2014-15.

These national average rates mask significant variations in different geographic and Health Education England (HEE) regions (figure O); in 2014/15 the highest joining rate of 16% was in South London, and the lowest was in North East England (7%). Overall, turnover rates have tended to be higher in London and South East England than elsewhere in the country, highlighting a more pronounced recruitment and retention challenge for NHS trusts and other employers in those regions.

**Figure O: Nurses joining and leaving the workforce (headcount) by HEE, 2014/15**



Source: Provisional monthly NHS workforce statistics Sept 2012-13; Sept 2013-14; Sept 2014-15.

## No shortage of applications

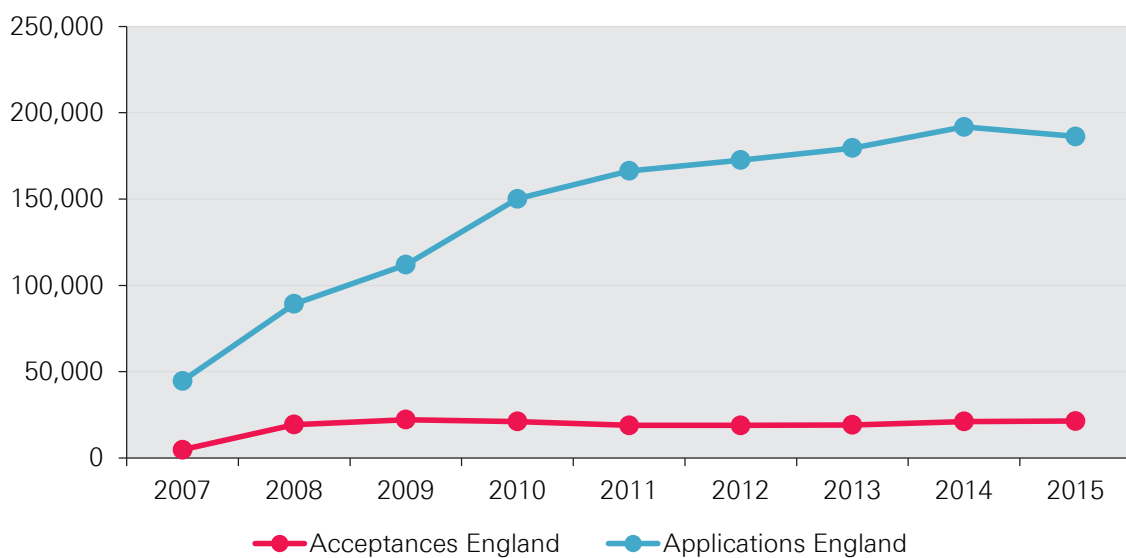
Despite media rhetoric about shortages, there has been a continuous trend of many more applications than funded places in pre-registration education for the health professions. Data from UCAS highlight long-term applications for pre-clinical medicine at around 50,000 per annum (figure P), while applications for pre-registration nursing have increased (figure Q), peaking in 2014 at almost 200,000.\*

**Figure P: Number of applications and acceptances for pre-clinical medicine training in England, 2007–15**



Source: UCAS data and analysis.

**Figure Q: Number of applications and acceptances for nurse training in England, 2007–15**



Source: UCAS data and analysis.

\* Note: individual applicants can make multiple applications.

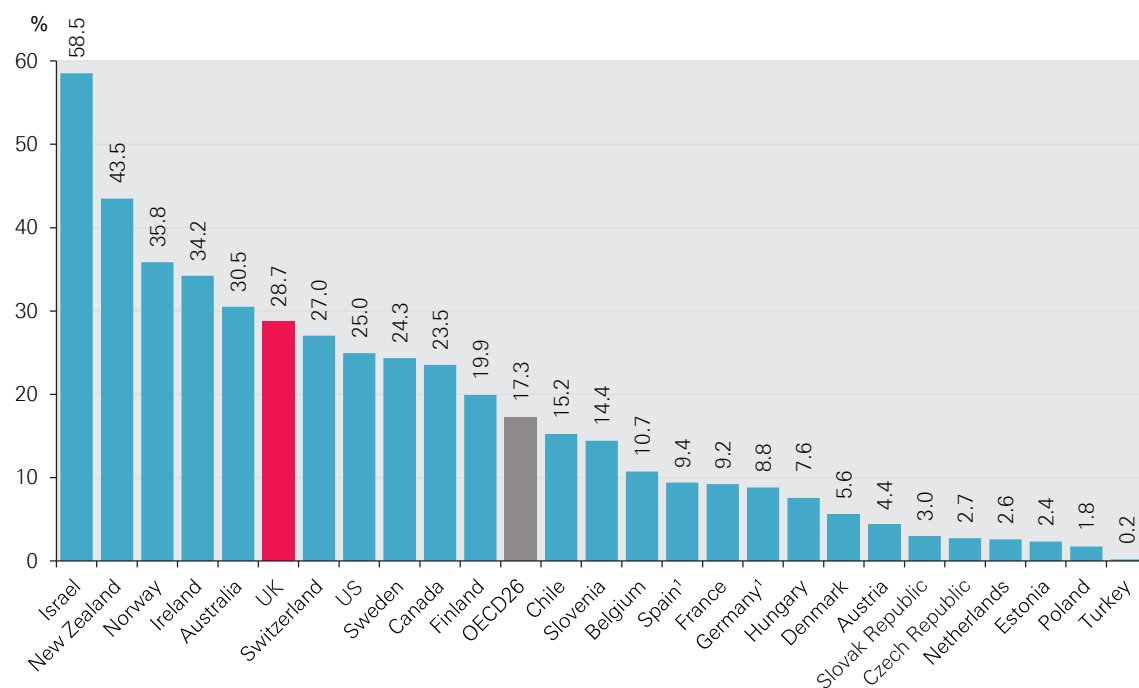
## The international connection: significant, long term, and more coming than going

The UK is both a source and destination country for mobile health professionals. Overall it is a significant net ‘importer’ of doctors, nurses and other health professionals;<sup>5</sup> this international inflow has made a major contribution to meeting domestic demand.

The international connection is in part a legacy of empire; in part a result of being able to tap into a very large international population of English speaking health professionals; and, more recently, in part enabled by access to freely mobile health professionals in other countries of the EU.

The overall result is that the UK has one of the highest levels of reliance on internationally trained health professionals of any OECD country (see figures R and S). About one in three doctors, and one in eight nurses, in the UK was trained in another country.

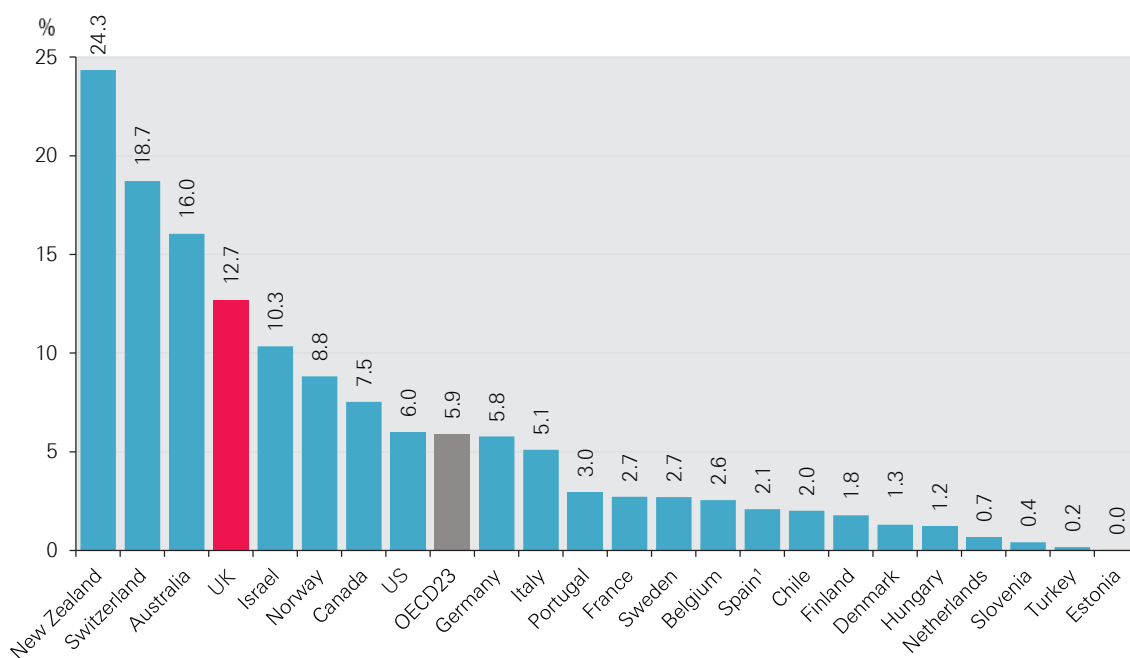
**Figure R: Percentage of doctors who were foreign trained, 2013<sup>2</sup>**



Note: 1. Data for some regions in Spain relate to foreign nationality or country of birth, not the place of training.

Source: OECD Health Statistics 2015, <http://dx.doi.org/10.1787/health-data-en>.

**Figure S: Percentage of nurses who were foreign trained, 2013<sup>2</sup>**



Note: Data for some regions in Spain relate to foreign nationality or country of birth, not the place of training.

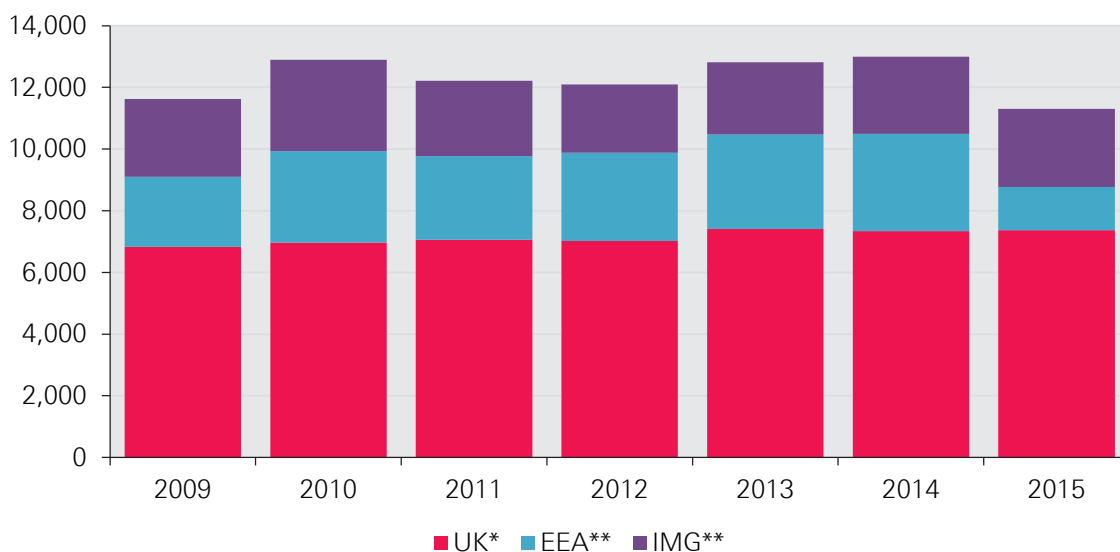
Source: OECD Health Statistics 2015, <http://dx.doi.org/10.1787/health-data-en>.

Actual annual flows of health professionals into the UK vary year by year. Trends in inflow of health professionals to the UK can be tracked using professional registration data. This data may overstate actual flows, as not all who are registered will necessarily move to – or work in – the UK, but does provide insights into annual trends, and information on source countries. Data from the General Medical Council (GMC) (figure T) and Nurses and Midwives Council (NMC) (figure U) can be used to assess the relative size of annual inflows from training in the UK, and from international sources. Figure T shows that annual inflow of new doctors from UK training has increased in recent years – reflecting increased medical school intakes a decade ago – while the number from the EU dropped in 2015.

Data on the inflow of nurses, as measured by registration data, is shown in figure U. Inflow peaked in 2002, at the peak of the last round of active international recruitment, when international (EU and non-EU) sources accounted for more than half the total number of new nurses entering the UK register. It then dropped rapidly, but has increased since 2009, with EU countries accounting for most of the increase.



**Figure T: Number of PMQ doctors on the GMC register with a licence to practise at year end, 2009–15**



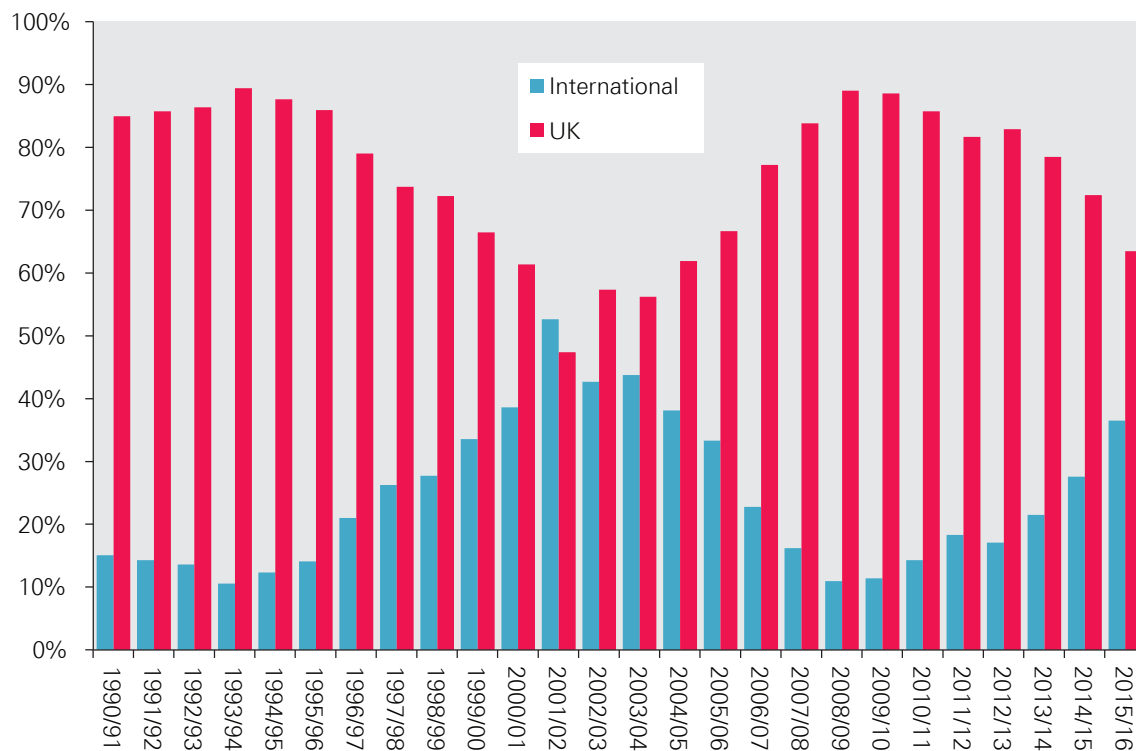
\* The number of UK PMQ doctors whose PMQ date is the same as the year we are looking at.

\*\* The number of EEA or IMG PMQ doctors who first joined the register in each of the years we are looking at.

Note: Licensing was introduced in 2009. From this date, a doctor is required to hold a licence in order to practise in the UK.

Source: General Medical Council (GMC) data.

**Figure U: International and UK sources as a % of total new admissions to the UK nursing register, 1990/91–2015/16 (initial registrations)**

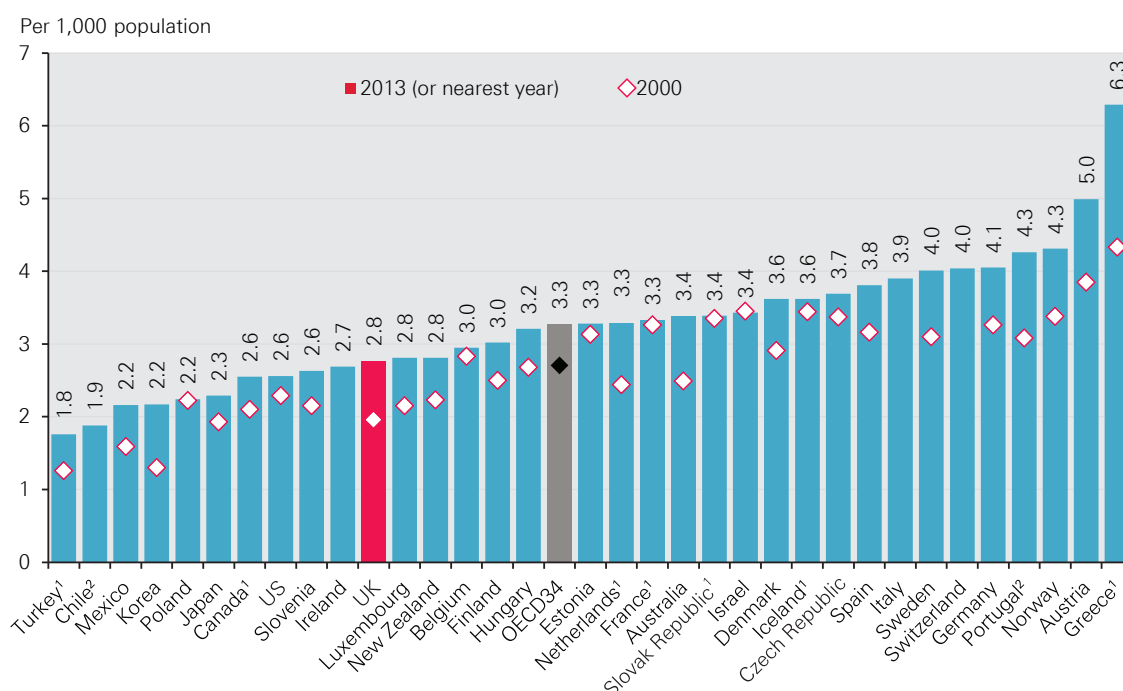


Source: UKCC/NMC data, the authors.

## International comparisons: UK below OECD average, but not an outlier

Data from OECD provide an opportunity to compare the UK's workforce profile with other OECD countries.<sup>6</sup> Such comparisons must be undertaken with caution because of differences in data collection and definitions. The two most relevant comparisons available are the doctor:population ratio, and the nurse:population ratio. These data are presented below for 2013 (the most recent available year), with 2000 also presented to give some sense of change over the last 10 years.

**Figure V: Numbers of doctors per 1,000 population in OECD countries, 2000 and 2013 (or nearest year)<sup>6</sup>**

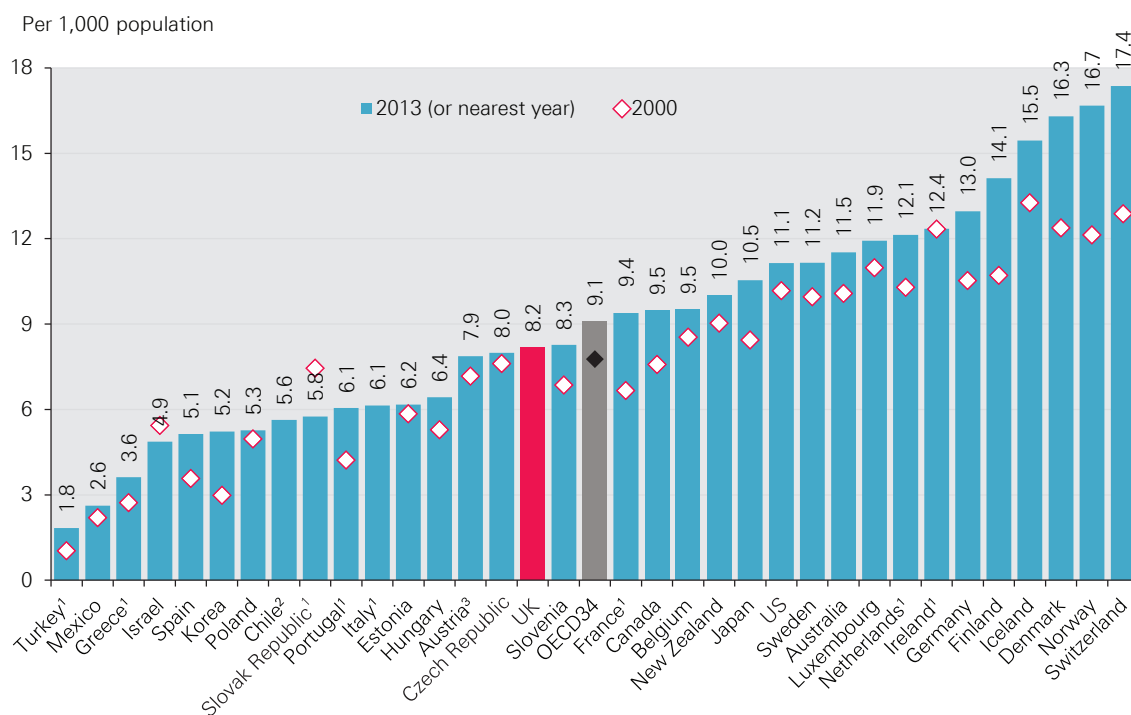


Notes: 1. Data include not only doctors providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. (adding another 5–10% of doctors). 2. Data refer to all doctors licensed to practice (resulting in a large over-estimation of the number of practising doctors in Portugal, of around 30%). Information on data for Israel: <http://oe.cd/israel-disclaimer>.

Source: OECD Health Statistics 2015. <http://dx.doi.org/10.1787/888933325971>.

The OECD data suggest that in 2013 the UK had a doctor:population ratio of 2.8 per 1,000 population, which is not dissimilar to the US, Canada, Ireland and New Zealand, but is below the OECD average of 3.3 (figure W). Countries with high ratios of doctors tend to be those that have relatively low nurse:population ratios (eg Greece, Portugal and Italy), or countries that have higher expenditure on health overall. The UK, like many other countries, reported significant growth in the doctor:population ratio over the period since 2000.

**Figure W: Practising nurses per 1,000 population, OECD countries, 2000 and 2013 (or nearest year)<sup>6</sup>**



Notes: 1. Data include not only nurses providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. 2. Data refer to all nurses who are licensed to practice. 3. Austria reports only nurses employed in hospital.

Information on data for Israel: <http://oe.cd/israel-disclaimer>.

Source: OECD Health Statistics 2015. <http://dx.doi.org/10.1787/888933325986>.

The nurse:population ratio in the UK in 2013 was reported to be 8.3 per 1,000 population, below the OECD average and lower than Canada, Australia, the US, New Zealand and countries in Scandinavia. One factor explaining the relatively low ratio reported for the UK may be the fact that the UK only deploys one level of registered nurse, whereas many other countries have a ‘second-level’ nurse; another is the lower rate of new graduate nurses that have emerged from training in the UK compared with most other OECD countries in the period since 2000.

## NHS staff pay: A freeze on flexibility

Most NHS staff have their pay determined centrally and nationally, through a range of occupation/professions-related review bodies. This national approach to pay determination has in the past been criticised for reducing the ability of individual NHS trusts to respond more creatively and flexibly to local labour market challenges. At various times over the last 30 years, numerous local and regional pay setting mechanisms have been mooted, but in practice none have achieved any real traction in the NHS.

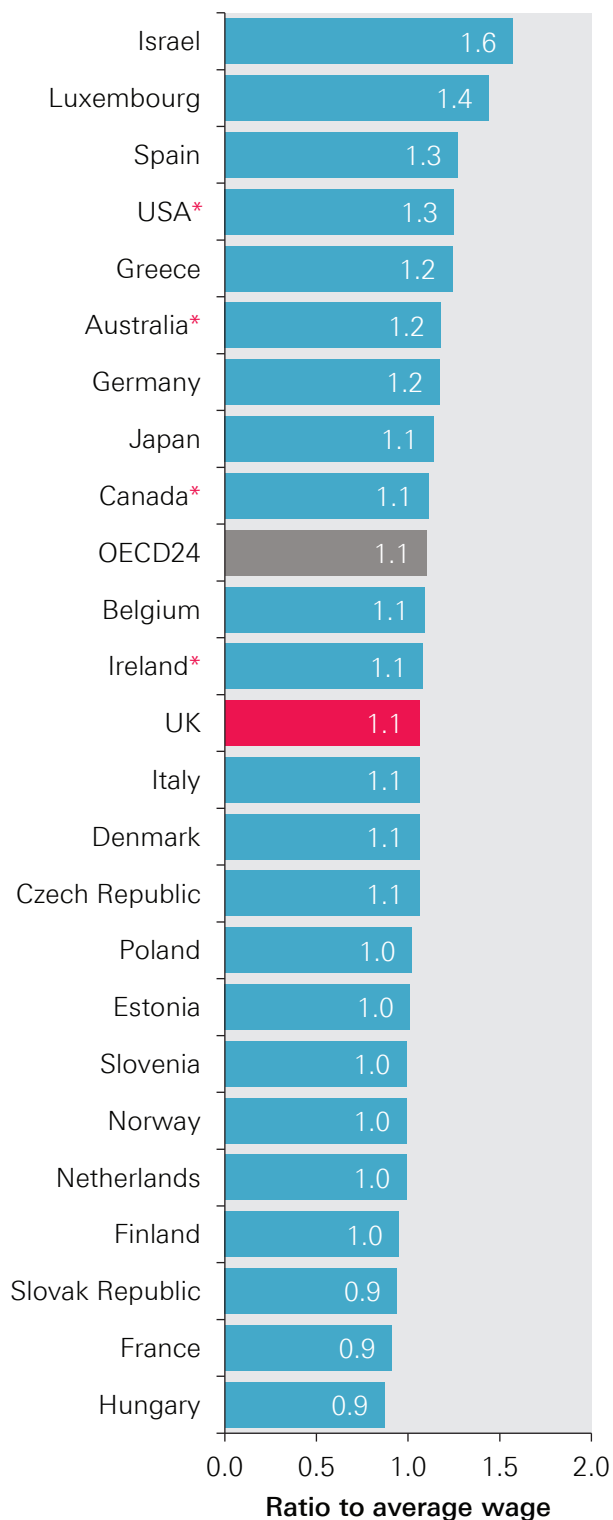
Pay comparisons are fraught with definitional difficulties, but OECD data presented in the two figures overleaf give some sense of the pay relativities for hospital nurses in the UK, and in comparison with their peers in other countries. Figure X shows the remuneration of hospital nurses in OECD countries compared with average wages in the same countries. By this measure, hospital nurses in the UK earn just above the average wage in the UK, similar to the OECD average (1.1), but lower than nurses in some other OECD countries. When converted into US dollars to allow a more direct comparison of purchasing power parity (PPP) (figure Y), UK hospital nurse remuneration is ranked as 15th out of 30 OECD countries, just above the OECD average, but below the US, Canada, Australia and most countries in Northern and Western Europe.

Although characterised as inflexible by critics, the main pay system for most NHS staff does have some degree of flexibility built in, such as recruitment and retention premiums and a 'market forces factor', but in practice these have not been much used by local management – because of lack of capacity, or lack of resources. However in more recent years, the centralised pay system has enabled a system-wide NHS pay 'freeze' to be more easily sustained as part of overall fiscal constraint after the global financial crisis, in comparison to a decentralised or localised system. The most recent NHS staff pay constraint was announced in the 2015 Budget and is scheduled to remain in place for four years, capping annual increases at 1%.<sup>7</sup> If it does extend through to the end of the period, there will have been a 10-year period where NHS pay has been centrally restrained.

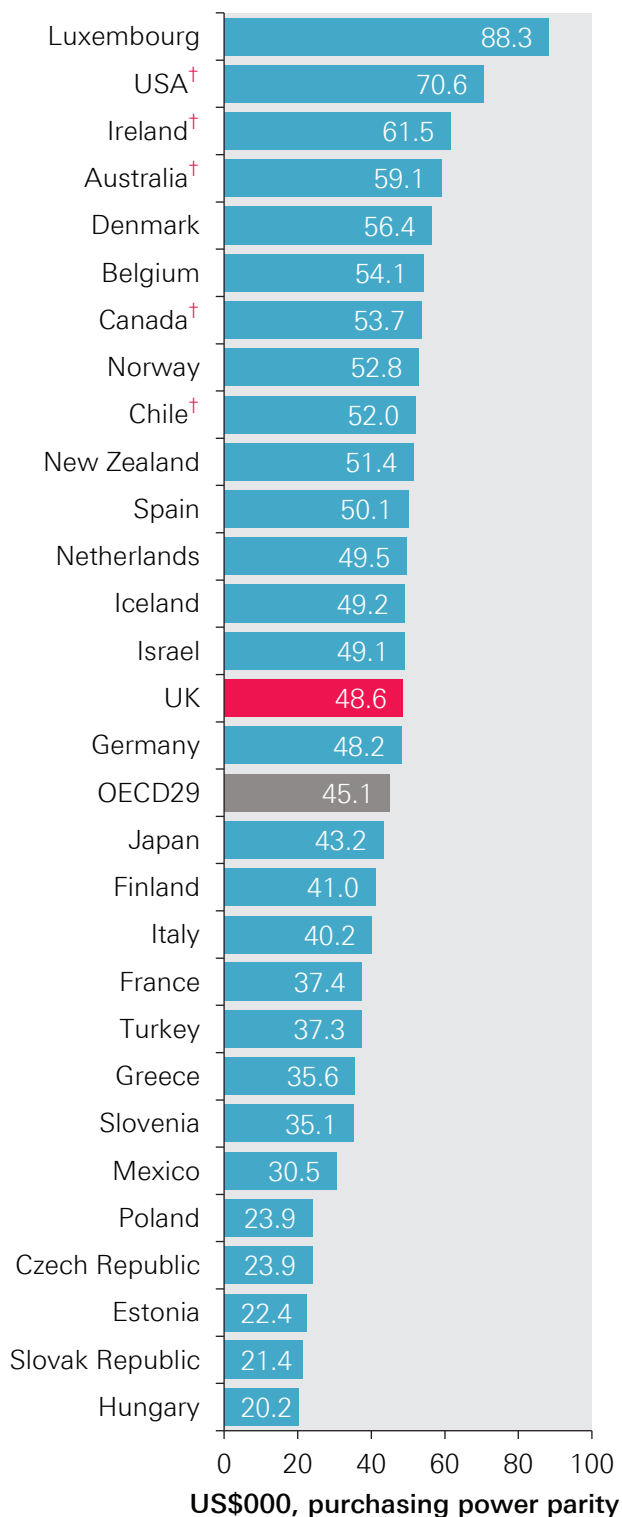
There has been a general trend in European countries hit by the crisis to contain costs through public sector pay restraint, and in some countries this has included a policy shift away from local pay bargaining to national level in order to enable more effective national pay bill control.<sup>8</sup>

Pay determination should be a lever to improve performance and service delivery. It should also recognise the contribution of staff, and motivate them to continue to contribute. The longer the centralised 'freeze' goes on, the less pay and associated reward can be a policy lever to achieve these objectives, locally or nationally.

**Figure X: Remuneration of hospital nurses, ratio to average wage, 2013 (or nearest year)**



**Figure Y: Remuneration of hospital nurses, US\$000 purchasing power parity, 2013 (or nearest year)**



\* Data refer to registered ('professional') nurses in the US, Australia, Canada and Ireland (resulting in an over-estimation).

† Data refer to registered ('professional') nurses in the US, Australia, Canada, Ireland and Chile (resulting in an over-estimation).

Source: OECD Health Statistics 2015, <http://dx.doi.org/10.1787/health-data-en>.

## Current profile and recent trends: summary

Staffing and funding levels are inexorably linked in the health sector, given the labour-intensive nature of system delivery. Given NHS funding constraints it is therefore not surprising that NHS staffing growth in England has generally tailed off in recent years, compared with the rapid growth exhibited in the early part of the last decade (when there were significant year-on-year increases in NHS funding).

Even so, there has been marked variation in staffing trends, with higher levels of growth reported for senior hospital medical staff and for GPs than for the other professional staff they work alongside, notably for NHS nurses, numbers of which have increased by about 9% since 2005, and mainly in the early part of the period. In contrast, 'workload' has continued to rise year on year, suggesting that staff must either been working harder or more productively, however defined and measured.

Data on applications and intakes to health professional education in England does not suggest any shortage of willing applicants in comparison to funded places. In the English NHS system, where almost all pre-registration education for the main health professions is funded by government, the 'production' constraint is funding allocation, not applications.

The available information on international inflows of health professionals to England highlight long term, variable, but often relatively high levels of reliance on international nurses and doctors. International comparisons highlight that the UK has well above the OECD average of foreign trained doctors and nurses.

International comparisons suggest that England has lower staffing:population ratios than the other three UK countries, and is slightly below the OECD average for nurse:population ratios and for doctor:population ratios.

The other obvious manifestation of NHS funding constraint has been centralised pay restraint, which is currently scheduled to continue through to 2019. It has essentially marginalised the use of pay as a policy lever to support changes in productivity and service delivery.

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The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care.