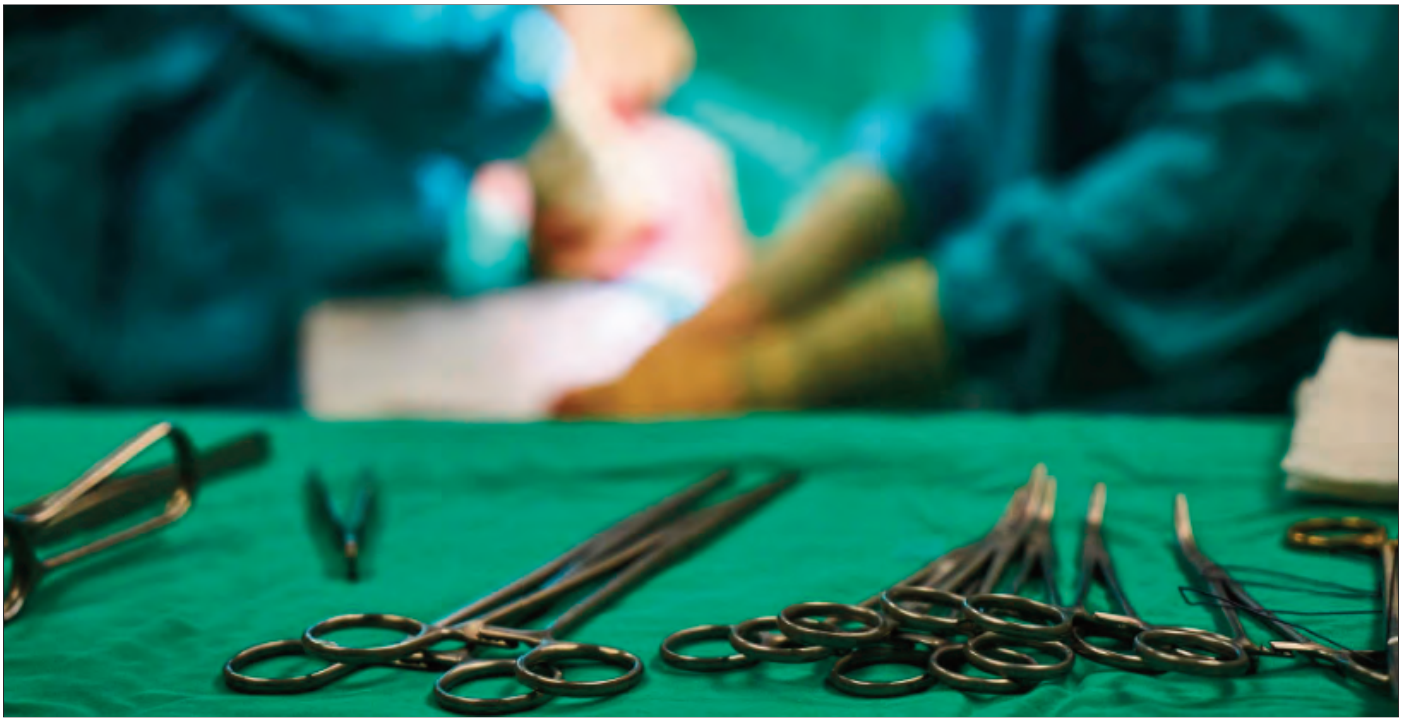
The lowdown

Health news and analysis to inform and empower NHS staff and campaigners

# Harsh financial reality and cuts bite in new NHS organisations



**Reality is beginning to bite for the new Integrated Care Boards (ICBs) as their promises of achieving a financial break-even by the end of 2022/23 look to be fading fast for many.**

At the halfway point in the 2022/23 financial year, HSJ has found that two out of three ICS are not on track to break-even and many are likely to have to report large deficits in their first year of operation, despite them signing up to break-even plans at the start of the year.

This news comes as no surprise, as The Lowdown reported back in May that almost all of those ICS for which figures were available were already projecting substantial deficits in their first year in charge. With all of their projections also likely to be undermined by the growth of inflation.

Since May inflation has escalated and the ICSs have also reported pressure due to the previous year's Covid funding being cut by more than half, the additional funding for hospi-

*continued on page 2...*

## *Also in this issue...*

*...continued from page 1*

tal discharges (Hospital Discharge Plan) ending, and having to spend more on agency staff due to staff shortages. The ICSs have struggled to deliver savings to reduce deficits.

Back in March 2022, HSJ reported that guidance from NHS England circulated to local leaders, set out a hard line on ICS finances:

"NHS England and NHS Improvement intend to use additional powers in the legislation to set a financial objective for each integrated care board [the local commissioning body] and its partner trusts to deliver a financially balanced system, namely a duty on break even."

This month, Lincolnshire's ICS has requested permission from NHS England to report a financial deficit at the end of the year, after warning its budgets will be overspent by £35m by the end of November.

Despite this, HSJ reports that the ICS is still officially forecasting that it would close the gap by the end of the year.

Indeed, most of the 21 systems which are not on track to reduce their deficits are suggesting they will recover their position by year-end, according to the HSJ article.

One target for cost-cutting will be staff numbers in the ICB, which have been formed from several CCG. Amanda Pritchard, CEO of NHS England, has said ICBs will need to "rationalise roles [and] processes" and use "economies of scale" to cut costs."

Lancashire and South Cumbria ICB *[which manages Barrow Hospital, pictured below]*, struggling to contain costs, has launched a voluntary redundancy scheme for staff, in an effort to reduce its staffing bill by 20%.

There are no plans for compulsory redundancies, according to Kevin Lavery, L&SC chief executive, but he warned that if there was a low take-up of the voluntary scheme it would mean cuts to patient services.

The ICB is also reducing its offices from six to two, which is expected to save £650,000 each year.

### Major challenges ahead

Although the Chancellor's additional £3.3bn per year for NHS England in both 2023-24 and 2024-25 was a better outcome than most people probably expected, the challenges for the ICSs are many – more than a quarter of ICSs across England have at least one in five beds occupied by patients who are fit for discharge, industrial action is on the horizon, the waiting list for elective care is over 7 million, and the backlog maintenance bill is over £10bn. Against this background it will be a major challenge for any of the ICS to even reduce their deficits, let alone break-even.

# Moves to avoid NHS strike action?

**Royal College of Nursing members will strike on 15 and 20 December at employers across England, Northern Ireland and Wales "after the UK government rejected our offer of formal negotiations".**

The health secretary, Steve Barclay invited six unions to the Department of Health and Social Care (DHSC), "to discuss workforce issues", but trade unions attending suggested that Barclay had "sidestepped" the key issues of pay and patients safety.

In a joint statement afterwards, the unions reported telling the secretary of state that "patient waits for treatment would carry on worsening, unless something was done about the dangerously low staffing levels affecting every part of the NHS.", and making it clear that "decent wages are key to stopping employees leaving and to turning the NHS into an attractive employer for potential recruits."

Commenting on the meeting, UNISON head of health and chair of the NHS unions Sara Gorton said: "There can be no solution to the damaging workforce crisis unless the government improves NHS pay."

Unite national officer for health Colenzo Jarrett-Thorpe said: "The government must put forward a better pay deal and one that is not funded from already mercilessly squeezed budgets?"

Action will not take place in at least 40% of NHS locations as turnout was below the 50% legal minimum.

In July, the government in Westminster announced that most NHS staff on Agenda for Change contracts (NHS terms and conditions) in England would get a pay rise of £1,400, in line with the recommendation of the NHS pay review body – 4% for nursing grades.

### Progress in Scotland?

The RCNs strike plans in Scotland have been paused after the Scottish government committed to formal negotiations over pay. An initial offer of 5% was increased to a flat rate increase of £2,200, or 8% for a newly trained nurse but was rejected by the RCN. Talks have renewed after Nicola Sturgeon met with Pat Cullen, the general Secretary of the RCN.

For staff in some of the lowest paid, the latest offer would represent an 11% rise, and is worth 7.5 across all pay bands. UNISON, who represent 50,000 health staff including nurses, midwives, cleaners and porters, is recommending their members accept it, as the "largest ever" rise for the lowest paid.

Wilma Brown, chair of UNISON Scotland's health committee, said: "We have decided to recommend this offer to our members, as we believe it's the best that can be achieved through negotiations. It will go some way to helping NHS members with the cost-of-living crisis.

"However, as we have said to the Scottish government, there's a huge amount of work to do to get our NHS back to being world class again. This must be the start of the reforms and investment needed to get the NHS back to full health."

### Breakthrough deals for NHS staff

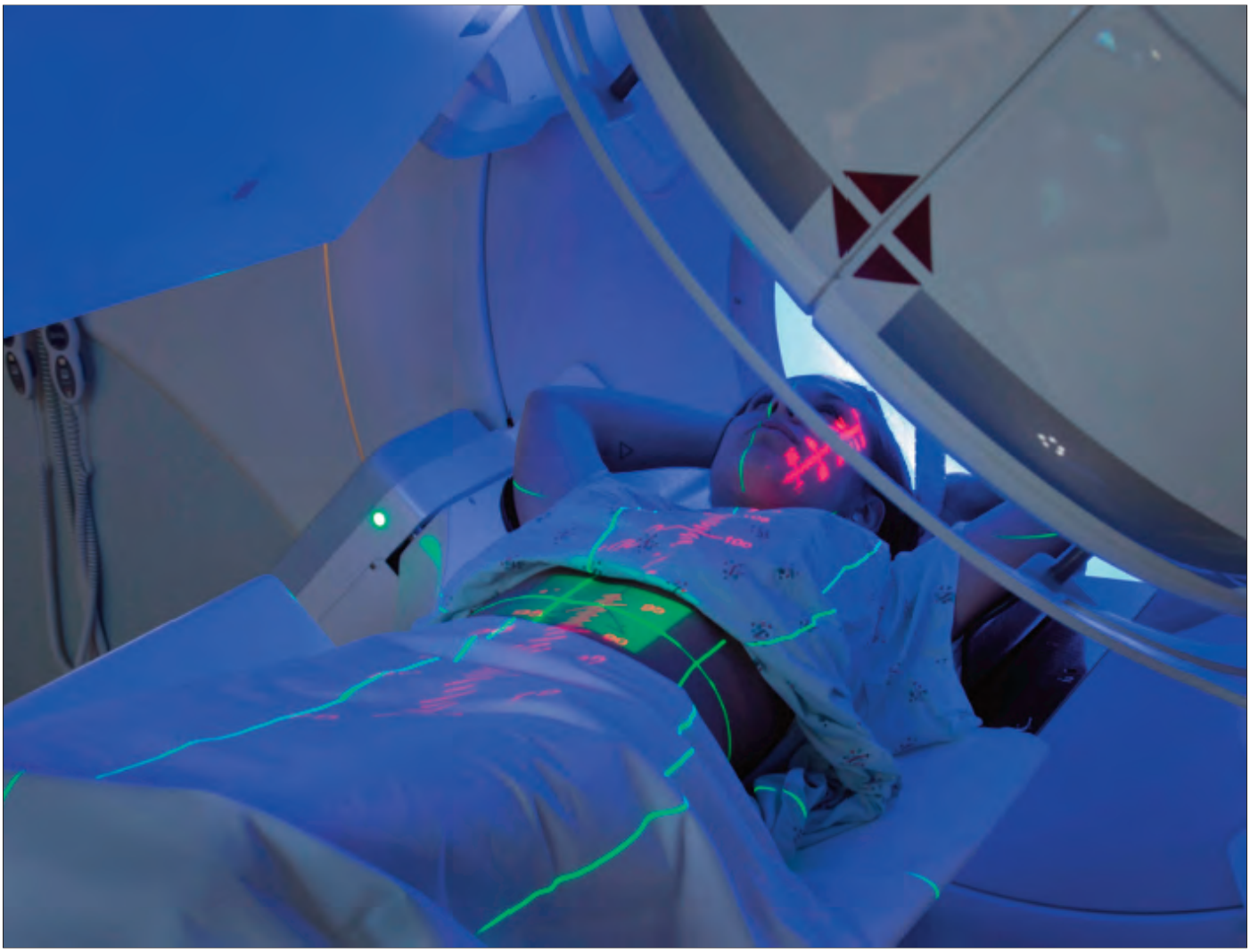
Earlier this month the health union Unite announced that a deal with Barts Health trust had been secured to bring linen and laundry staff back in house from May next year. Staff will receive significantly improved terms and conditions in the move away from the outsourced service currently provided by Synergy.

"Not only will workers get a pay boost up to 17 per cent, they will also get NHS terms and conditions going forward.

Back in March Unite struck another agreement to bring 1,800 NHS workers employed by the outsourcing company Serco back into NHS employment. The Trust's board confirmed that the change will take place when the current contract with Serco expires at the end of April 2023.

Cleaners, porters, security guards, and domestic staff will be transferred across to join the existing 17,000 Barts Health staff as NHS employees under Agenda for Change (AfC) conditions.

# Why has Hewitt been given the latest NHS 'review' brief?



**Jeremy Hunt's decision to bring in former Labour MP and cabinet minister Patricia Hewitt to help his government 're-form' the NHS has brought her record as health secretary from 2005-7 sharply back into focus.**

While the press release accompanying the move – described as a "review of how integrated care systems can best be empowered and supported to succeed" – omits all mention of Hewitt's past political affiliation, some of the 'trigger' terms included (like "cutting through red-tape" and "enhancing patient choice") strongly hint at the policies once enthusiastically embraced by the Blair appointee during her time in office.

Hewitt's record at the Department of Health & Social Security (as it was then known) – skated over by some sections of the media, but revisited with confected anger by others – wasn't entirely without merit, as she was responsible for pushing through the ban on smoking in public places. That move saw hospital admissions for heart attacks fall by 2.4 per cent immediately, the equivalent of 1,200 heart attacks a year.

But it was her stance on commercial interests being given a greater role in the health service that caused most concern while she was health secretary, a stance which may yet resurface in her latest role.

Shortly after taking up the health secretary post in 2005, Hewitt invited private tenders for a round of 'independent sector treatment centres', worth around £500m a year, but excluded NHS hospitals from the bidding process. Publicly-owned NHS treatment centres, meanwhile, were deemed likely to be handed over to private operators.

Around £400m-worth of scans, blood and pathology tests were also to be hived off, all part of plans to double the volume of private sector work purchased by the NHS, with at least 10 per cent of elective operations handed over to the independents.

These and other proposals naturally proved controversial, and in November that year, in a speech to community health chiefs at the NHS Alliance annual conference, Hewitt had to apologise for publishing plans which would have forced primary care trusts (PCTs) to contract out all district nursing, family planning clinics and other local health services. She also had to reassure delegates that a forthcoming white paper would water down proposals to create competition between NHS GPs and private clinics across England.

Such contrition proved short-lived, however, as the following January saw the launch of a white paper which sought to push PCTs to outsource all services. Hewitt went on to tell a press briefing that there was "widespread enthusiasm" among staff to leave the NHS and work for social enterprises instead.

And later in 2006, private insurance companies were invited to bid for a large slice of the £64bn NHS commissioning budget then controlled by PCTs, and public sector procurement body NHS Logistics was carved up in order to award a contract to Texas-based Novation.

Competence issues also arose during Hewitt's tenure at the DHSS. She oversaw the introduction in 2007 of the MTAS, a computerised job application system for junior doctors which, because of security issues, led to personal details – phone numbers, home addresses and sexual orientation – becoming publicly available. Hewitt was forced to apologise for the "needless anxiety and distress" that the move had caused.

Back in 2008, while still an MP, Hewitt may have benefited from her time as health secretary when she was offered consultancy roles with both Cinven, a private equity company that had just bought up BUPA's UK hospitals for £14bn, and pharmacy chain Alliance Boots. One newspaper report at the time suggested these two roles would have netted her at least £100,000 a year.

Then, two years later, a Channel 4 Dispatches investigation into political lobbying claimed that Hewitt had appeared to suggest she was being paid £3,000 a day to help a client get a seat on a government advisory group. That allegation led to her being suspended from the Labour Party.

***Martin Shelley***

**What does the review signify?**

As for Hewitt's brief to review the workings of the brand new integrated Care systems there is little detail apart from headline promises.

"The government has announced a new independent review into oversight of ICSs to reduce disparities and improve health outcomes across the country."

Which apparently includes giving ICSs "greater control and making them more accountable for performance and spending, reducing the number of national targets, enhancing patient choice and making the healthcare system more transparent."

It is doubtful that the government intends to make the ICSs more accountable to the public, for they are certainly more remote and no more transparent than the Clinical Commissioning Groups they replaced. More likely are further restrictions on Integrated Care Boards to stick to their budget despite the horrible compromises that they will face from the fresh squeeze on funding.

Nobody wants to see public money wasted but this kind of review reinforces the fantasy that there is a rich seam of efficiencies that can be made in a system that outperformed the wider economy in terms of productivity improvement before the pandemic, and which has year on year been forced to carve out savings during long periods of underfunding over the last decade.

There are ways to work smarter, improve connectedness between services, and employ new technology, but these require time, space and money to bring them online. They are not a replacement for a realistic plan to raise staffing levels.

"Patient choice" has traditionally translated into the wider involvement of independent providers. Beyond that it is hard to see how a system which is so low on capacity can offer more than words on issues like choice, most patients would opt for the earliest appointment date possible and patients are already travelling to find the care that they need.

"Local flexibility and freedom from national targets" on the other hand may well have some appeal for NHS managers beset with demands from all sides, but what it means in policy terms is completely unclear.

So what is the purpose of the Hewitt review? – Early indications are that it is far from a serious attempt at meaningful support and improvement, more likely is that it serves as a distraction from the neglectful reality of the recent financial statement, that even now, the NHS still lacks a fully funded plan to steer it out of the crisis.

***Paul Evans***

# Long-term consequences of cuts to public health services becoming clear

**After over a 100 years of progress, the health and well being of the British public is now going in reverse, according to Andy Haldane, the chief executive of the Royal Society of Arts giving the Health Foundation's REAL Challenge lecture.**

"We're in a situation for the first time, probably since the Industrial Revolution, where health and wellbeing are in retreat," he said.

This trend can be seen in recent data published by the Health Foundation on the increasing number of people aged 50-69 not working due to ill health.

The reasons for this trend are complicated, but the Health Foundation noted that although Covid-19 is a factor, due to long Covid and the backlog in health care, the problem began before the pandemic.

One major factor is that just as public health services have been the main driver of increasing the health of the population for more than one hundred years, their downgrading and underfunding over successive Conservative governments is now a major contributor to a reversal of all those years of progress and a reduction in the health and wellbeing of the nation.

Therese Coffey's short-lived tenure at the DHSC and Liz Truss's as PM briefly highlighted public health services and they became the subject of headlines, as it was reported that anti-smoking and anti-obesity measures would be reversed or not put in place. With Coffey and Truss gone, public health services have once again faded into the background of concerns, with A&E waits and ambulance backlogs taking up the headlines.

But history has shown that public health services are the most important component of healthcare – they are the services that focus on disease prevention and over more than 160 years, they have almost doubled life expectancy for men and women, and enabled the UK population to live much healthier and longer lives than each previous generation, and thereby remain active in the community for longer either working or volunteering.

Public health services provide preventative services, including smoking cessation, drug and alcohol services, children's health services, including health visitors, and sexual health services, as well as broader public health support across local authorities and the NHS. They are provided primarily by local authorities, although some service provision is shared with the NHS, and are funded by a grant from the Department for Health and Social Care (DHSC) budget.

### Value for money

The public health interventions put in place by local authorities are excellent value for money. Calculations by researchers at Cambridge University show that each additional year of good health achieved in the population by public health interventions costs £3,800, which is three to four times lower than the cost resulting from NHS interventions of £13,500.

The researchers suggest that investing in local public health programmes would generate longer and more healthy lives than equivalent spend in the NHS.

One would think that given the overwhelming evidence of excellent value for money of public health interventions and their importance for a healthy population that would ultimately rely less on the NHS, a government would do everything it could to promote and fund public health services. That it would not just protect public health spending in real terms, but actively increase it in absolute terms.

Well you'd be wrong, in fact the exact opposite has taken place over the past 12 years of Conservative governments.

An editorial in the BMJ in September 2022, highlighted how after over 10 years of Conservative government the importance of public health services has been downgraded and they have been chronically underfunded.

The editorial notes that since 2010, successive Westminster governments have "dismantled and defunded public health rather than recognising the importance of a healthy population and a robust and effective public health function."

The central public health agency, Public Health England, has been abolished and replaced by the UK Health Security Agency, and this has dropped public health from its title. Three of the four chief medical officers in the UK are not public health doctors and local directors of public health were transferred from the NHS to local councils, authorities which have at the same time been steadily underfunded.

**Most deprived are the worst hit**

As well as downgrading public health within the healthcare system in England and Wales, the actual amount of funding that is provided for public health services fell by £1 billion from 2014/15 to 2021/22, or by a massive 24%.

The cuts to funding have taken place across all local authorities, but it turns out that the areas seeing the biggest real-term per person cuts are those that are the most deprived with the poorest health outcomes – in fact those areas that are most in need of and will benefit the most from public health services.

For example Blackpool, ranked as the most deprived upper tier local authority in England, had the largest cut to its grant at £42 in real terms per person since 2015/16, according to the Health Foundation.

Back in 2019, the IPPR also found that the cuts in public health disproportionately affected the most deprived areas. When the IPPR compared the cuts in the most and least deprived ten local authorities, they found that "Almost £1 in every £7 cut from public health services has come from England's ten most deprived communities – compared to just £1 in every £46 in the country's ten least deprived places. The total, absolute cuts in the poorest places have thus been six times larger than in the least deprived."

Analysis by The Health Foundation of spending from 2015/16 to 2021/22 found that some of the largest reductions in spend over the period were for stop smoking services and tobacco control, which fell by 41% in real terms, drug and alcohol services for adults (28%), and sexual health services (23%).

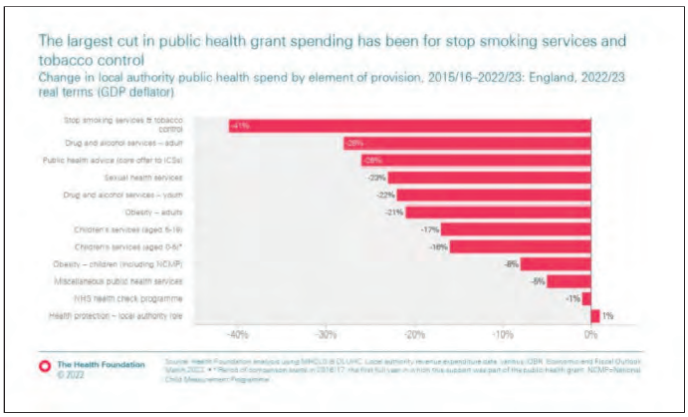
Despite a commitment in the Autumn 2021 Spending Review to maintain the public health grant in real terms until 2024/25, due to escalating inflation cuts will continue as the grant is already set to fall in real terms in 2022/23, according to analysis by The Health Foundation. There have already been severe cuts to services.

In April 2022, there was a cut of £100 million in funding for weight management services, due to be shared between the NHS and local councils, despite research showing that these services, a broad range of health advice, information and behaviour change support services, can be an effective intervention to support lasting health improvement. Another blow to public health services.

Sexual health services, in particular, are struggling. Danny Beales, Head of Policy & Campaigns at National AIDS Trust, in a recent HSJ article appealed for more money for these services, noting: "The government must also urgently increase resources to sexual health services to relieve capacity issues. These services have been at breaking point due to public health funding decreasing for some time. Add to this the diversion of capacity to Monkeypox and potentially to help with the response to NHS winter pressures, the current situation is unsustainable. We risk waiting lists for PrEP piling up, and ultimately we will see transmissions of HIV that were entirely preventable."

The ultimate effect of this reduction in public health services, is that opportunities to prevent the early deterioration of health will be missed – people who with the right interventions might have given up smoking or alcohol, will now go on to lead shorter, more unhealthy lives with all the additional negative consequences that can have for people around them and for costs to the NHS.

Ultimately a failure to invest in vital preventative services will mean poorer health for a higher proportion of the country's population at a younger age, an increase in costs for the NHS, a fall in the number of people available to work, and the widening of health inequalities. In the long-term a lack of investment in public health services will have negative consequences across all of society and the economy.



# A workforce already stretched over five days, can't stretch to seven

**With the waiting list of patients waiting for planned NHS care at over 7 million, up from 4.4 million before the pandemic, and performance against cancer and A&E targets at a record low, the idea that the NHS should be working flat out seven days a week to increase activity is once again being voiced.**

Andrew Stein, a consultant in renal and general medicine, told BBC Radio 4's Today news programme:

"The NHS simply won't work unless we work seven days a week. No individual has to work seven days a week, but there's no reason why we couldn't have two shifts, for example, with one team working Monday to Thursday and the other one [working] Thursday to Sunday."

Stein likened Friday afternoon in an NHS hospital as being like the 'Mary Celeste', with people starting to head to the car parks at 12 and by 2pm it's all quiet.

Reacting to Stein's comments, Vishal Sharma, chair of the BMA's Consultants Committee, said: "Hardworking doctors and NHS staff will not recognise the description of the NHS being like the Mary Celeste on a Friday afternoon. These comments are hugely disrespectful and very disheartening when the truth is that the NHS is under extreme pressure and staff are routinely having to work above and beyond to provide care for their patients."

Who knows what happened to the crew of the unfortunate Mary Celeste, but the NHS staff that Stein talks about leaving by 2pm, will be leaving after having worked a full week and may well have also done several hours overtime. The issue is not the staff leaving, but that there are not enough staff to replace them and as a result the NHS can not do as much elective and non-urgent work over the weekend. Sharma noted that:

"The fundamental issue is that there are not enough staff during the weekdays, let alone across seven days. Stretching an already overstretched workforce across a seven day window will not increase the number of patients that get treatment but would arguably be even more damaging to patient care as a result of diluting the number of staff available each day."

Chief executive of the NHS Confederation, Matthew Taylor, also told the Times that it's not because the NHS does not want to carry out non-urgent work over the weekend, there is just not the staff to do so:

"The NHS is there for everyone who needs it every day of the year, including primary care carrying out well over one million appointments most Fridays and urgent and emergency care services routinely being busier over weekends than during the week. While many trusts would like to provide more non-urgent services over the weekend like some elective care, they simply lack the staff to do so."

And why isn't there enough staff to do weekend working, well Taylor places the blame firmly with the government:

"the failure of successive governments to provide a fully funded workforce strategy to help tackle the NHS's 132,000 vacancies, to address the maintenance backlog of £10 billion, and to provide proper support for social care, with local communities and frontline staff all paying the price".

The Conservatives made a manifesto promise to recruit 50,000 more nurses, but despite ministerial claims to be on track with nursing recruitment, the target will be missed by 10,000 according to the latest predictions. And as Dr Kevin O'Kane, a Consultant in Acute Internal Medicine, wrote on Twitter:

"We don't have enough doctors for a fully-staffed five day service. This is because staff are leaving in droves because of a decade of pay cuts & a perverse pensions tax system whereby we have to pay to come to work."

In July 2022, the health and select committee within Parliament also placed the blame for the staffing shortage with successive governments. The report confirmed what everyone working in the NHS has known for many years, that the NHS has a major staffing crisis and the Government has shown "a marked reluctance to act decisively" and produce a meaningful workforce plan.

**Dodging the issue**

Not only has the government not produced a workforce plan, they voted against an amendment to the Health & Social Care Bill 2022 that would have required the government to publish independently verified forecasts of the workforce numbers needed across the NHS to ensure that services are safely staffed.

The lack of staff means that if staff worked at the weekend then shifts on weekdays would be empty. To fill those places to ensure patient safety the trusts would have to employ more and more locum and agency staff.

The cost to hospital trusts of locum and agency staff is already astronomical, in 2021/22, the cost to the NHS of agency staff was up 20% to £3 billion. Trusts spent a further £6 billion on bank staff, when NHS staff are paid to do temporary shifts, taking the total spent on additional staff to around £9.2 billion.

Research undertaken by the Labour Party found that some hospital trusts have had to pay over £2,000 for a single agency nurse shift; out of 60 responses from trusts, 10 reported the most expensive shift cost over £2,000, and for another 13 it was between £1,000-2,000. The Royal Cornwall Hospitals Trust has been particularly badly hit by nursing shortages and paid £16.4 million to agencies who provide NHS staff on short notice in 2021/22.

Employing more staff to enable weekend working would seriously impact on trust budgets, which are already being eroded by escalating inflation.

There is also the issue of capacity. If elective surgery increases at the weekend where would the patients be looked after post-surgery? In September it was reported that more than 13,000 of the 100,000 NHS hospital beds contain "delayed discharge" patients. This has resulted in A&E units becoming full and long delays in ambulance handovers. If it is extremely difficult to find a bed in a hospital for an emergency case, how would a bed be available for a patient post-elective surgery?

**Social care leaders sceptical**

The government has promised to tackle this issue. Back in September, ministers announced a £500m emergency fund – a new adult social care discharge fund – to get thousands of medically fit patients safely discharged home or to a care home. This was part of the government's Plan for Patients. The NHS Confederation noted that the quicker the money was released and allocated "the quicker the NHS and local government partners can invest it to tackle what the Care Quality Commission is calling 'gridlock'."

Finally on 17 November, the DHSC announced that the NHS will get 60% of the funding via integrated care boards (ICBs) and 40% allocated to councils, who will then have to agree how the funding is used. The funding will appear in December and January.

Social care leaders have criticised the delay and are sceptical of the funding's impact on the issues of the social care sector, with several social care leaders referring to it as a "sticking plaster" for the sector's problems. The Association of Directors of Social Services (ADASS) has warned that 94% of directors did not believe they had enough money or workforce to meet needs this winter, according to its latest survey.

In 2021-22, the number of vacancies across adult social care rose by 55,000 (52%), while the number of filled posts fell by 50,000. Several councils plan to tighten eligibility to receive social care and two of England's biggest councils, Hampshire and Kent, have said they risked bankruptcy as a result of "12 years of austerity", inflation and mounting demand for adults' and children's social care. The massive funding and workforce problems faced by social care, means that the fund will have little impact on the issue of delayed discharges.

It is clear that until the government addresses the workforce issues in both the NHS and social care with pay awards and a sensible workforce plan, then weekend working will remain impossible if patients are to be cared for safely.

# Is the NHS finally going to get its workforce plan?

**A year ago Jeremy Hunt was sitting on the back benches, and as chair of the health select committee was pushing an amendment to the Health and Social Care Bill – to enforce assessment of NHS, social care and public health staffing needs. He failed but helped to strengthen the case for a properly funded workforce plan and now as chancellor has the chance to deliver it. Has he? No, not yet.**

As health secretary (2012-18), Hunt was part of the coalition austerity government that consistently neglected NHS workforce planning, helping to create the crisis that is now producing delays in treatment, suffering and unnecessary deaths.

Now, despite running the treasury Jeremy Hunt still hasn't removed his department's long standing resistance to backing a funded workforce strategy. Given his personal stance on the issue and the loud consensus for action, it was a glaring omission from his recent financial statement, but he has turned up the dial on his pledge;

"the Department of Health and Social Care and the NHS will publish an independently-verified plan for the number of doctors, nurses and other professionals we will need in five, 10 and 15 years' time, taking full account of the need for better retention and productivity improvements."


### But where's the funding?

Although the announcement was welcomed by commentators and NHS England, pledges, reviews and unfunded strategies have been seen and heard over the last four years, the cash for implementation remains the missing element.

As The Health Foundation noted:

"The Chancellor's commitment to publish long term workforce projections is very welcome but doesn't yet come with any additional funding or plan to expand the workforce."

Pressure from organisations within the NHS for a funded workforce plan has been building, most recently a coalition of over 100 health and care organisations, including the Royal College of Physicians (RCP), signed a letter to the Chancellor in support of publishing the NHS long-term workforce plan in full, including assessments of how many staff will be needed to keep pace with demand.

Commenting on the plan announcement, the RCP noted:

"It is vital that the workforce plan, when it is published next year, comes with a clear commitment to provide the funding necessary to make this happen."

There certainly is nothing spare going in the current budget for the NHS for the workforce plan. The Autumn statement included an extra £3.3bn for the NHS in each of the next two years, but experts have warned that this amount is probably only half of what is needed to keep the health service going.

Only last month NHS England forecast a £7bn shortfall in its funding next year, a black hole which it warned could not be filled by increased efficiency measures alone. As a result, GP services, cancer care and mental health treatment may be some of the areas that will face cuts.

NHSE is now committed to submitting projections of long-term workforce requirements to the Department of Health and Social Care by April 2023, DHSC officials, however, have not committed to a timeline for publishing the projections, or that they will be published in full.

At whatever date the workforce plan is published, it will remain just a plan unless funds are committed to it to increase training and improve retention.

# Should the NHS still be recruiting from overseas?

**The NHS has a major workforce crisis, with over 132,000 vacancies overall and over 47,000 vacancies for registered nurses.**

The recruitment of nurses and other staff from overseas is often promoted as a quick fix for some of the staffing issues. Most recently, Therese Coffey, in her brief spell at the DHSC, commented that if nurses left the NHS, overseas recruitment could fill those places.

In September 2022, NHS England announced additional funding for NHS trusts in England for overseas recruitment. They are now able to claim £7,000 from NHS England per overseas nurse recruited between 1 January and 31 March 2023. In Scotland an additional £8m will be spent on recruiting nurses from overseas to help ease the workforce crisis in Scotland this winter.

This may ease the troubles of the NHS somewhat, but with the shortage of healthcare personnel, in particular nurses and midwives, now global, according to the WHO, should overseas recruitment take place at all.

### Poorer countries losing trained staff

The global trade in healthcare staff, in particular nurses and midwives, is huge and has been going on for decades. The UK is not the only country to rely on overseas recruitment, the USA, Canada and many other developed nations have healthcare systems that are heavily reliant on a steady stream of staff trained overseas, in particular nurses.

Over many years a hierarchy has developed in healthcare staff recruitment, and it is the richest countries, including the USA, Canada, Australia and the UK, that have occupied a top position for a long time, whilst low income countries are the ones that train staff, but then see them quickly lured away by the richer nations.

In Caribbean countries, for example, 40% of nursing positions were vacant, mostly as a result of nurse migration, according to research published in 2020. Jamaica's Ministry of Health noted in its 2016-2017 annual report:

"Over the last three years, Jamaica lost 29% of its critical care nursing workforce to migration, which has severely hindered the capacity to deliver efficient and effective care."

For most countries that 'export' nurses, the exodus has depleted and prevented the development of an adequate healthcare system. Its affect led the World Health Organization (WHO) to set up a red and amber list of countries to try and apply a code of practice to healthcare recruitment.

Last updated in 2021, the Red List contains 47 countries where no active recruitment should take place, due to the very low numbers of healthcare personnel in the country. The amber list contains countries where an agreement exists between two

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countries for recruitment, but no recruitment outside of this agreement can take place. Of course none of this stops individuals in these countries applying for jobs in the richer nations.

The Philippines, as many people will know, set themselves up as the world's leading exporter of nurses, but even here limits on 'exports' were introduced in 2020, mainly as a result of the high number of Covid patients needing care. In 2019, around 17,000 Filipino nurses took up jobs in other countries, the limit was set at 5,000 in 2020, although it has since been increased somewhat.

**Call for richer nations to invest domestically**

International nurse leaders have called for richer countries to invest in home-grown staff and address the retention of staff. In September 2022, the chief nursing officer of the WHO Elizabeth Iro, Speaking at the Queen's Nursing Institute's (QNI) annual conference, urged the governments of developed nations to "really make the investment in nursing, and grow your own workforce".

Her pleas were echoed by Howard Catton, Chief executive of the International Council of Nurses (ICN) who agreed that wealthier countries, including the UK, should invest more in training up their domestic workforce instead of relying on international recruitment.

However, despite the pleas from international nurse leaders, the UK continues to encourage recruitment from overseas, and worse still from countries on the WHO 'red list', including Nigeria, Pakistan, and Ghana. Nursing Times reported that an examination of the Nursing and Midwifery Council (NMC) register between April 2021 and March 2022 found that three of the top seven countries from which the UK recruits overseas nurses are on the WHO's Red List.

In September 2022 it emerged that the DHSC has signed a deal with the red-listed Nepal. The 15-month deal is for nurses to work at Hampshire Hospitals Foundation Trust, which runs services in Winchester, Basingstoke and Andover.

As a result of the deal Nepal was moved to the Amber List. Nepalese media were quick to question why registered nurses are being sent to work in the UK, when Nepal has its own shortages and does not meet the WHO recommended nurse-patient ratio.

It is a difficult balancing act for the governments of developing countries, however. They lose trained staff, but it is difficult to deny their citizens the right to migrate and for those nurses who leave it is a life-changing experience, not only for them, but for those they leave behind as money is nearly always sent back to family, which can make a big difference.

However, as the global shortage of healthcare staff increases it is difficult to see how a rich nation, such as the UK, which has had years in which to invest in training staff, but chose not to, can justify destabilizing another country's healthcare system. Furthermore, these poorer countries are also the ones that are now suffering the negative consequences of climate change, which means it is even more important that they develop good healthcare systems and retain educated citizens.

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