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The Association of Independent Professionals and the Self-Employed

“The role of self-employed people in resolving the workforce problems in the NHS”

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Foreword

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Two characteristics are consistently part of the story of the NHS.

The first is that the NHS is recognised to be the world's first universal healthcare system, which enjoys virtually unanimous political support at home and widespread respect abroad. Against this background it is quite right that there is a heavy burden of proof on anyone wanting to argue the case for changing or developing the practices and institutions on which the NHS has been built.

Although this is a positive story there is also a second characteristic which is part of the NHS story, and which is in many ways the flip-side of the first.

The success of the NHS in securing improved outcomes and political support from citizens, coupled with its experience of a wearying series of bureaucratic disruptions, has led to a small "c" conservative tendency within the service. Too often the NHS has been both protective of its inherited institutions and a slow adopter of clinical and working methods that improve the care available to today's generation of patients.

The NHS approach to self-employment is a case in point.

The traditional model of NHS employment has involved a commitment to a full-time salaried role, with an expectation that the great majority of recruits will work until they reach a formal retirement age, after which they will draw an NHS pension.

That model has many benefits. Most importantly it provides a mutual commitment – that the employee will commit to being available within defined times and the employer will provide a reward package which underwrites the employee's personal and family obligations.

But this approach no longer reflects the only model available to potential recruits. Society has moved on – and the NHS has not always kept up. Many people now make choices about their lives which do not involve full-time commitment to a single employer; they prefer arrangements that allow them to flex their working lives so that they can meet other obligations and priorities.

NHS employers need to respond to these challenges and this report, supported by IPSE, is intended to highlight some of the issues involved.

The development of more flexible working patterns is sometimes seen as synonymous with bad employment practice and dismissed as the "gig economy". There have certainly been too many occasions when that has been true, but the right response to bad employment practice cannot be to conclude that the NHS can only offer employment on terms which reflect historic practices.

If some people feel pressured to take exploitative zero-hours contracts against their will, that issue should be addressed as an abuse, but it is not a reason to deny more flexible working arrangements to others for whom such contracts provide the optimum outcome.

Quite apart from the need to respond to wider social trends, the NHS has two reasons of its own to think more seriously about these issues than it has yet done.

Firstly, if NHS employers are concerned about bad employment practices and wish to set standards by which others are judged (and most do), they need to demonstrate that the NHS is responding to the developing demand for more flexible working practices and offering a range of opportunities which are fair to both employer and employee.

Secondly, NHS employers also need to recognise that this is not only a matter of doing the right thing – it is also the only the way that the NHS is going to be able to meet its growing staffing requirement. We all know that staff shortage is a challenge facing virtually every NHS organisation (and many other employers in the economy). More flexible NHS employment practices are an important part of the response to that challenge, and this IPSE-supported report is a timely reminder of the role which professional self-employed people can play.

Executive summary

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The NHS is by far the biggest employer in the UK – and the fifth biggest in the world. It employs 1.5 million people, and the connected adult social care sector employs another 1.34 million. And yet in both, there is said to be a chronic staffing shortage – a shortage that is believed to be seriously affecting the quality and efficiency of healthcare in the UK.

If health and social care in the UK are to be improved, there must be a serious discussion about the state of the NHS and care sector workforce,and one of the top areas of concern: flexibility and self-employment.

- The NHS urgently needs to become a better employer, with a more integrated, mixed both flexible and full-time employed workforce.
- Across other sectors, having a more flexible workforce significantly improves productivity.
- As part of a more flexible workforce, the self-employed could therefore do much to help solve the NHS staffing crisis.
- At present, NHS contractors and the challenges they face do not seem to be taken seriously: this must change.
- At present there are numerous barriers to flexible working in the NHS and care sector – especially the changes to IR35.
- The CEST tool for judging IR35 status has been significantly undermined by a series of high-profile failures.
- To encourage a more flexible workforce, the NHS and care sector must address barriers like IR35 and do more to encourage self-employed people to work for them.

As the Health Foundation outlined its 2017 report, 'Rising Pressure: the NHS Workforce Challenge', NHS services are being compromised by staff shortages, planning inadequacies and an inability to make best use of workforce skills.

Workforce retention is also a serious and growing problem, including among the university-based academic workforce.

It is important that the healthcare sector reflects the changing society it serves. Many people want to contribute their skills and expertise to the country's public services, but they also increasingly want to live balanced lives that give them time for their families and other priorities. To find this balance, they are looking for more flexible and adaptive working situations. If the health and care sector cannot accommodate this flexibility, it will increasingly struggle to compete with other sectors for staff.

Flexible working patterns and various forms of self-employment are sometimes dismissed as the "gig-economy", and it is true, sometimes more flexible work models can conceal exploitative behaviour and bad employment practices. However, this is a very small minority of cases, and far more often, introducing flexible working patterns leads to genuine improvements in staff welfare. The health and care sector needs to introduce such changes if it is to successfully compete in today's labour market.

This is important for health and social care employers, and also for Government, given that 10% of employment is NHS and social care. It is not yet clear how the NHS and social care sector can create a system that offers the flexible employment practices many wish to see. With widespread reports of worsening staff shortages, however, it is now vital to consider how it can be created.

This paper focuses on outcomes rather than particular models. It considers ways the health and care sector can offer its staff flexibility and the healthier work-life balance people across all sector strive for.

It centres around a number of key questions:

- Are we correct that for the sake of its workforce, the health and care system needs to be more open to new models of care?
- In terms of employment, what steps need to be taken to make this happen?
- Why is the NHS different to other employers? Has this impeded the development of flexible employment models?
- What are the consequences of the IR35 changes?
- What are the barriers to delivering a modern, flexible workforce?

Recommendations:

This report concludes with a number of recommendations for improving conditions for the self-employed in the health and care sector, increasing the number of people working flexibly in the sector, and thereby beginning to tackle its staffing crisis:

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1. Tax compliance regulations such as IR35 should not be a hurdle to the development of flexible workforce models and the deployment of external expertise and capacity, as part of running an efficient NHS service.

2. NHS Trusts need to consult with their HR service to better understand the issues in planning and managing their workforce and NHS hiring managers must recognise self-employment as a model which can benefit their organisation.

3. A new contract needs to be approved by HMRC – a changing society means more flexible working practices are going to be needed.

4. Pay bargaining could be undertaken to better empower the self-employed in contract negotiations.

5. The difference between scrupulous and unscrupulous contracts needs better understanding. There must be greater transparency on the employment status established within a contract and how working arrangements are to be agreed between parties.

6. There needs to be a definition of self-employment recognised by HMRC and NHS employer bodies.

7. HEE and NHS Employers should work together to consult on what form such a new definition should take which can then be recognised by HMRC.

"Rising pressures – the challenges facing the self-employed"

Since April 2017 HMRC has changed IR35 self-employed tax laws in the public sector. The changes mean that in the public sector it is no longer the self-employed who determine the status of their working engagement; it is public sector client bodies. The purpose of HMRC's changes was to more clearly identify all working engagements and pick up on 'disguised employment'.

Staff are usually engaged through an agency, and it is notoriously difficult to determine the status of long-term self-employed engagements in the public sector. To help determine whether engagements are employed or self-employed, the Government created an online tool (Check Employment for Tax/CEST tool) that asks a series of questions then makes a determination based on the answers.

The Government view

The Government commissioned research, published in May 2018 by IFF Research and Frontier Economics, which focused on three main areas: public administration and defence, education, and health and social work. This pointed to issues such as blanket assessments, increased costs, rising fees, difficulties recruiting and an increased administrative burden on the public sector bodies dealing with the new IR35 system.

Overall, it is claimed public authorities quickly overcame these problems. HMRC estimates an additional £410 million of income tax and NICs has been remitted and there has been no increase in the use of umbrella companies. Both IPSE and IHPA (the Independent Health Professionals Association) dispute these findings.

It is unclear, however, if there will be an equivalent reduction in Corporation Tax because of the wider impact of these changes.

IPSE and CIPD's research

IPSE has done further survey work – in partnership with the Chartered Institute of Personnel and Development (CIPD) – with results based on 1,290 contractors and 115 hiring managers, more than 80% of whom are from NHS Trusts.

The survey found:

- Almost a third (31%) said they were previously working in the public sector, but had not been since the introduction of the IR35 changes

- Over two thirds of these attributed this directly to the IR35 changes in April 2017
- 75% of hiring managers said it has become harder to recruit contractors
- 71% of hiring managers say it has become harder to retain contractors in the public sector
- Almost three in ten (29%) of freelancers ensured their contract would end before the changes came into effect

IHPA's study

The Independent Health Professionals Association (IHPA) questioned 537 independent healthcare staff on a range of issues affecting their working lives. A key question they posed was: 'What's putting the biggest strain on care provision in the NHS?' with respondents listing:

- Staff shortages
- Funding cuts
- Management
- Internal bureaucracy
- Wastage and the number of patients using the service without genuine need.

Locum respondents said the IR35 changes will reduce patient safety because of cancelled or delayed patient appointments, the extra financial drain of hiring HR and accountancy professionals to assess the IR35 status of locums, as well as the extra workload from having to make IR35 assessments.

APSCo's research

The Association of Professional Staffing Companies (APSCo), whose members supply central and local government in areas such as IT, IT digital and social worker professionals, also researched this issue. This pointed to a reduction in the use of personal service companies since April 2017 and suggested there had been an increase in 'umbrella employed' workers.

The cost of resourcing contractors has increased because of the scarcity of resource, as well as increased statutory costs. It has become more expensive overall – particularly in roles where there was already a scarcity – because of individuals increasing their rates.

The research recognised that the public sector does not have access to the tools and expertise needed to make correct Off-Payroll determinations.

Beyond IR35: the self-employed in the health and care sector

While the principle of clamping down on 'disguised employment' is widely accepted and supported, there has been little discussion of the implications of the IR35 changes. Nor has there been a wider discussion about the role self-employed contractors play in tackling the severe workforce challenges in the NHS and social care sector.

There remains significant confusion about IR35 and how to assess an engagement properly. It should be more widely recognised that assessments differ depending on the profession and the role. Because of the confusion and complexity, however, it is clear many trusts are applying blanket assessments instead of judging each case individually. Anecdotal evidence from agencies also suggests the changes to IR35 have had a significantly negative impact, with expertise lost to the private sector and most clients simply not understanding the required changes.

To maintain HMRC's 'tax take' as efficiently as possible, the direct engagement model also needs to be revisited, and the NHS and social care sector must work to ensure the correct type and level of tax is always being paid for its staff.

- We want the NHS to be a better employer, with a more integrated, mixed workforce
- Shortages and over-supply are core issues for the NHS, and IR35 is not seen as connected to these and therefore low down the list of priorities
- There is a lack of confidence in CEST because of several reported system failures, as well as a perception that it is having a negative impact on its service users. Government should therefore either reform it or replace it with a system that works.
- What does a flexible workforce system look like?
    - If we were to start again, what would the system look like?

What the self-employed contribute to the NHS

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The Health Education England (HEE) workforce strategy notes that there are several factors driving the NHS staffing shortage, including regulation changes such as IR35. When reviewing resourcing in the NHS, it is clearly essential to consider the self-employed.

HEE's workforce plan

HEE's workforce plan is centred around six principles. First, there must be integrated service, finance and workforce planning, which does not exist at present. NHS leadership is never fully clear on how much staffing is needed, what the offer is to the patient, what is a reasonable workload for NHS staff, what productivity levels are expected and what is considered a safe staffing level. This lack of a strategic approach is one of the biggest factors behind the NHS's recruitment and retention problems.

It is important to understand what exactly 'flexible workforce' means and the implications of that for team design, the breaking down of professional territory barriers, the development of non-medical staff and the development of multi-disciplinary teams.

So far the focus has been on how to become a model employer, acknowledging, for example, that 40 per cent of registered nurses are not working in the NHS. Staff want the NHS to become a better employer – providing an offer that is more flexible and suited to modern working practices, rather than seeking other models of employment.

The changing workforce

HEE does, however, recognise there are other models that can serve the patient and taxpayer well – and that for social care, the employment landscape is fundamentally different. As we look to integrate health and social care, it will be important to address these differences and enable flexibility for staff across the sectors. The rest of the economy is changing and adopting flexible working arrangements, and the NHS must also adapt to the changing workforce.

There must be a more rational policy and strategy for the use of workforces from other sectors – whether independent contractors or private employers and agencies. There are numerous reports suggesting that a workforce made up of multiple sectors is more productive and inclusive. For a long time, policymakers have been encouraging the NHS to recruit talent from outside itself to help with information and experience sharing. It is felt this has stalled in recent years. This includes the interchange of staff between the NHS and social care providers.

In the debate about staff vacancies and shortages, it simply isn't acknowledged that approximately 90% of vacancies are covered by someone from a bank agency. Even more pressing, 5-7% of all shifts are simply not covered at all.

Currently there is a strong orthodoxy about being 'substantively' employed, which is understandable given the very real issues to do with adopting a more flexible and adaptive model – which would need to be addressed before it could gain significant support.

These issues include continuity of care and its effect on mortality levels, enabling peer support and review, creating team practice, CPD and career development and team versus task planning. It also relates to the question of what it means for whistle-blowing policies if employment rights are not directly with the NHS.

Incorporating flexible working

The NHS will always have 'temporary' staff to address operational peaks and troughs. It is also pressing for a 3-5% increase in its workforce at all times to reduce oversupply and shortages and support more efficient staff deployment.

However, there is still a reluctance to see independent contractors as part of a permanent resourcing strategy. In an organisation as large as the NHS, there will be times when external expertise or additional capacity will need to be brought in to address particular challenges or manage workflow peaks and troughs. This will ultimately help the organisation operate more efficiently. It should also be informed by what staff want: for example, speech and language therapists are more open to portfolio careers.

IR35 and other compliance, however, often act as a barrier to efficient workforce management and should be more properly considered by the NHS leadership.

Overall:

- Productivity improves with a more flexible workforce
- There is a need to change the culture within the NHS to take contracting staff more seriously
- A genuinely self-employed workforce is a solution to help solve the NHS workforce crisis
- Compliance barriers, such as the new IR35 system, should be lessened or removed entirely

Modern, flexible working in the health and care sectors

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A key question in any discussion about the NHS and social care workforce is what does flexibility mean?

Expectations and reality

For many younger employees coming into the NHS or social care, the expectation is often that they will have a portfolio career where they can change career or alter their pathway more than once – for example by taking a career break.

An increasing number of staff expect employers to provide a variety of flexible working options – and that they will not penalise them for pursuing their own path, including taking on a number of roles at the same time.

In the care sector, many staff are on zero-hour contracts, which is often seen as negative for them. However, there is also a strong supply of 'work' for them, and therefore an increased incentive for employers to engage them on more formal contracts. Yet, when the option is offered to staff to move onto fixed hour arrangements, many actually want to maintain the flexibility to dictate their hours and working pattern – so they can refuse work one week or not work more than a certain number of hours. This is seen at every level, including management consultants.

Why provide flexible working opportunities?

A key question is whether some of the staff working for agencies or as independent contractors are doing so because they need flexibility and a higher salary as a contractor, rather than out of a desire to work outside the formal NHS structure. Are staff choosing less than ideal working arrangements? If the NHS were to offer these flexible working opportunities – or other benefits from the independent contracting sector – would more people choose to work directly for it?

For nurses, two of the most attractive things about working through agencies and banks is that they offer better pay and more control over shifts and the days they work.

Fundamentally, the NHS and care sector must first assess the needs of the population and use that to determine the size of workforce needed – i.e. how much funding is needed and how to provide system accountability. Unless they start from that basis, questions about employment models will always founder.

Both the NHS and the care sector need to more clearly understand what kind of employment opportunities new and potential recruits are looking for. Only that way can they determine what would make an attractive employment package and actually encourage them into the sector. Job instability and lack of employment opportunities are big worries for younger people – and they are also more likely to find a job with social purpose more attractive. For the NHS and care sector to properly address the workforce shortage, they will need to consider factors like this.

Doctors and nurses: defining different approaches

For NHS Trusts, a bigger issue than IR35 or flexible working is the problems with the pensions 'lifetime allowance'. This is making many higher-paid staff ask themselves whether it is worth staying in the service at all. Anecdotal evidence suggests flexibility is sought more in medical roles, where trainee doctors are keen to spend time practising in other countries. This is driving some Trusts to run parallel training programmes to HEE that allow doctors to move around when they wish to.

While they may be able to facilitate flexible working for these groups, many clinical teams are often unwilling to do the same for nursing staff. They have often stopped them from self-rostering and working more flexibly because of concerns about managing demand and guaranteeing cover when it is needed.

Overall:

- More courageous leadership and development techniques are needed
- How do you reduce the administrative burden on medical practitioners?
- There is a big difference in the approach to medical and non-medical staff
- The issues to do with tax and pensions are a looming concern for the NHS

Conclusion

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Once legal accountability is shared and taken within the system rather than it resting with a particular manager, the discussion about flexibility will become easier.

If the focus became paying substantive staff 'properly', the cost of using agency staff would reduce as more people would choose substantive posts and the demand for agencies would fall.

Currently the system manages the workforce and financial challenge by driving staff into direct engagement, reducing the level of VAT paid. This is a strategy of tax avoidance and less care through reducing shifts.

There will always be times in any institution as big as the NHS when it needs specialist skills it cannot access among its permanent staff. When this happens, it will inevitably turn to external self-employed people. Being able to access them makes the NHS run more efficiently. Barriers such as IR35 are therefore unhelpful.

There are fundamental shortages in nurses and trainee doctors internationally, yet there has not been a proper discussion about the shortage of junior doctors. Similarly, removing nursing bursaries has affected the appeal of nursing as a career, given that other similar roles would leave people with a similar level of debt but twice the salary.

The main negative driver is staff shortages, so if this issue is resolved, attention can then turn to creating more flexible employment opportunities. This discussion would consider models that suit both employers and employees. It would also need to address how those contracts would look, including clinical audit, administrative work and a commitment to training and development.

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Further work should also be undertaken to understand what locums do, as many lead training for their departments, address CPD and clinical auditing.

The issue of a standard contract for locums – one that defines the expectations for a person in that position, including IR35 status – needs to be addressed and an attempt made to produce a definition of self-employment that HMRC recognises.

Recommendations:

1. Tax compliance regulations such as IR35 should not be a hurdle to the development of flexible workforce models and the deployment of external expertise and capacity, as part of running an efficient NHS service.

2. NHS Trusts need to consult with their HR service to better understand the issues in planning and managing their workforce and NHS hiring managers must recognise self-employment as a model which can benefit their organisation.

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