

| | | | | |
|--|---|---|---|------------------------------|
|  | Research SUMMARY | Authors JAMES BUCHAN RENU JOBANPUTRA PIPPA GOUGH | Key topics INTERNATIONAL RECRUITMENT LONDON WORKFORCE | Date JULY 2004 |
| Orders Free from: King's Fund Publications 020 7307 2591 or download at www.kingsfund.org.uk/summaries |   Queen Margaret University College |   Workforce Development Confederation |   Workforce Development Confederation | |

LONDON CALLING?

The international recruitment of health workers to the capital

THE KING'S FUND WORKFORCE PROGRAMME

Boosting the number of health care workers and making better use of their skills are central objectives of the Government's plans for NHS reform. But recruitment and retention remain major challenges for the health service – especially in inner cities. This King's Fund work programme:

- provides research and analysis from an independent perspective
- seeks to stimulate fresh ideas and informed debate
- works in partnership with others to develop effective practice, including London's network of HR managers, SHRINE, the workforce arms of London's five strategic health authorities, Queen Margaret University College, the Institute for Employment Studies, and the NHS Confederation
- seeks to transfer lessons learned in London to elsewhere in England
- seeks to learn from practice elsewhere in the UK and the rest of the world, and assess its relevance in London.

For updates, see www.kingsfund.org.uk/workforce

International recruitment of health professionals has grown rapidly in recent years, as the health service strives to increase its workforce to meet NHS Plan¹ staffing targets. London is more reliant than the rest of the NHS in England on international recruits because it has a higher level of vacancies and staff shortages than the rest of the health service. It has traditionally been the entry point for many international workers, who are attracted to the range of career opportunities and educational resources. Without these workers the health and health care services in the capital would be unable to function effectively.

However, London's reliance on the global labour market also brings with it a number of challenges. First, how can NHS employers in London support and develop an increasingly culturally and ethnically diverse workforce to enable it to work effectively? Second, how can London's NHS retain hard-won international health care staff in the face of growing international competition? And finally, how ethical is it for the NHS to continue to rely on health workers from developing countries and those experiencing their own shortages?

This research summary profiles, for the first time, the international workforce in London, and provides case studies detailing the experiences of three London NHS trusts and their international recruitment activities. The research is the first publication from a wider programme of work on the international recruitment of health workers to the capital.

ROUTES FOR ACTIVE RECRUITMENT

Doctors

The international recruitment of doctors to the NHS is centrally co-ordinated by the Department of Health (DH) but is targeted through a range of recruitment routes:

- **The Global Scheme** identifies doctors interested in working in England as consultants or GPs, and a specialist recruitment and response agency matches international applicants with NHS vacancies on their database.
- **The NHS International Fellowship Scheme** attracts experienced medical specialists to the NHS and is targeted at specialties 'where there is clear need for international recruitment to fill the expected number of vacancies and where additional incentives are required to attract high calibre candidates from overseas'. Fellowships are offered for up to two years.
- **The Managed Placement Scheme** is targeted at doctors at consultant level who are interested in working in the NHS, but initially wish to 'sample' working and living in England before applying for a substantive post.
- **The GP recruitment scheme** is targeted specifically at GPs.

NHS trusts can also recruit directly using agencies that are compliant with the DH's Code of Practice; the DH expects that this recruitment activity should focus on North America, approved areas of the Middle East, Australia, New Zealand and Europe (in the latter case, agreed not to overlap with Department-led initiatives).

Nurses and other health professionals

NHS international recruitment of nurses and other health professionals has been facilitated by regional co-ordinators based in strategic health authorities, who support employers in recruitment and co-ordinate recruitment activity between employers.

The DH has also launched the Nursing UK website (www.nursinguk.nhs.uk) for overseas nurses with the aim of supporting applicants from countries with which there are government-to-government agreements – currently Spain, the Philippines and India.

The growing number of health care professionals coming into the UK is, in part, a direct consequence of NHS policy. The Department of Health has made its support for international recruitment clear, with the aim of complementing home-based recruitment and retention initiatives to meet current NHS Plan targets for staffing growth.

International recruitment has offered a 'quick fix', with the import of ready-made health professionals. Reliance on training home-grown staff means waiting a minimum of three years, depending on the area of specialism. Initially a reactive measure in the late 1990s to help meet the first staffing targets, international recruitment is now an integral part of many NHS trusts' recruitment strategies. The Department of Health has established a number of specific routes for the active recruitment of doctors² and in 2001 it issued a Code of Practice on the international recruitment of staff to the NHS.³

Both the NHS and the private health care sector have been involved in recruiting internationally. There are several ways in which international health workers may enter the UK:

- **'active' recruitment** by employers or agencies. For example, the Department of Health is supporting international recruitment through a range of initiatives, such as a recruitment website for nurses, and an International Fellowship scheme for doctors
- **'passive' recruitment**, where overseas staff take the initiative to apply for health sector work in the UK
- as **skilled refugees**, who represent a significant but under-used health care labour resource (GLA 2002).⁴ Initiatives are now underway to facilitate their entry into the labour market, for example, by clinical attachments in NHS trusts. The BMA and Refugee Council keep a database of refugee doctors; in April 2003, 54% of the 849 refugee doctors on the database were based in London. A similar initiative for refugee nurses has been established by the Royal College of Nursing and the Department of Health.

Much of the activity to recruit staff from abroad to London and the South East of England is driven by staff shortages, and NHS staff vacancy rates are higher here than in the rest of the UK. London is the obvious first destination for many international health professionals. It offers an unparalleled range of career opportunities and educational resources. It is also home to a diverse population comprising a range of nationalities and ethnic backgrounds.

The danger is that London as gateway can become London as revolving door. The capital is likely to be the first port of call in the UK for employers and agencies looking to recruit experienced health care staff for other English-speaking countries. It has a large pool of internationally mobile health professionals. With its strong international connections it is part of a global market and will have to work hard to keep its staff.

While data is available on the overall number of staff coming to the UK, there has been little research to date on the impact of international recruitment to

DEPARTMENT OF HEALTH CODE OF PRACTICE GUIDING PRINCIPLES (2001)³

- International recruitment is a sound and legitimate contribution to the development of the NHS workforce.
- Extensive opportunities exist within the NHS for individuals in terms of training and education, and the enhancement of clinical practice.
- Developing countries should not be targeted for recruitment unless the Government of that country formally agrees via the Department of Health.
- Candidates should only be appointed who demonstrate a level of knowledge and effectiveness comparable to that expected of an individual trained in the UK.
- Candidates should only be appointed who demonstrate a level of English language proficiency consistent with safe and skilled communication with patients, clients, carers and colleagues.
- Staff legally recruited from abroad to work in the UK are protected by UK Employment Law in exactly the same way as all other employees.
- Staff recruited from abroad should have the same support and access to further education and training and continuing professional development as all other employees.

the health care workforce in London. This initial phase of work analyses this issue for the first time. We profile the overseas-trained health workforce and examine approaches to and experiences of international recruitment by three London NHS trusts. We then go on to highlight key policy challenges.

The next stage of our research, to be published early in 2005, will provide more detailed feedback on the experiences and aspirations of internationally recruited nurses currently working in London. We will conduct a survey with nurses that will report on their experiences of arriving in the UK; their levels of satisfaction at work; and their future career plans, including whether they intend to stay in the UK.

Research methods

This first phase of our research into London's recruitment of international health care workers is based on:

- desk research to build an overview of the UK picture on international recruitment
- analysis of data from the Nursing and Midwifery Council (NMC) to assist in building an overview of the London picture
- semi-structured interviews with human resources directors, international recruitment managers, liaison/support officers and data analysts in three London NHS trusts between September 2003 and April 2004, which form the basis of the case studies.

Background

The national picture

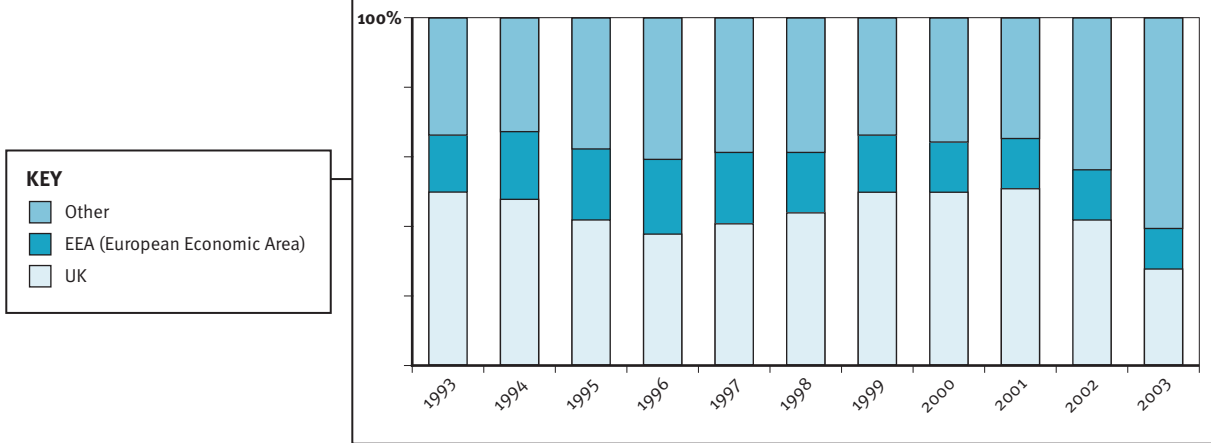
The importance of international recruitment to the UK's workforce is evidenced by two main trends: the number of workers coming to the UK from other countries (the 'flow' of workers), and the number of international health workers in the UK at any given time (the 'stock' of workers).

Doctors

There has been a significant increase in the 'flow' of doctors coming to the UK in recent years according to estimates derived from registration records and work permits registration data. In 2002 nearly half of the 10,000 new full registrants on the General Medical Council (GMC) register were from abroad; in 2003 this had risen to more than two-thirds of 15,000 registrants (see Figure 1 overleaf). Most of the growth has been in doctors from non-European Economic Area (EEA) countries.

In 2002/03, approximately 43% of new nurse registrants in the UK were from abroad.

1 DOCTORS: PERCENTAGE OF NEW FULL ENTRANTS TO GMC (UK) REGISTER FROM UK TRAINING, EEA COUNTRIES AND OTHER COUNTRIES, 1993–2003

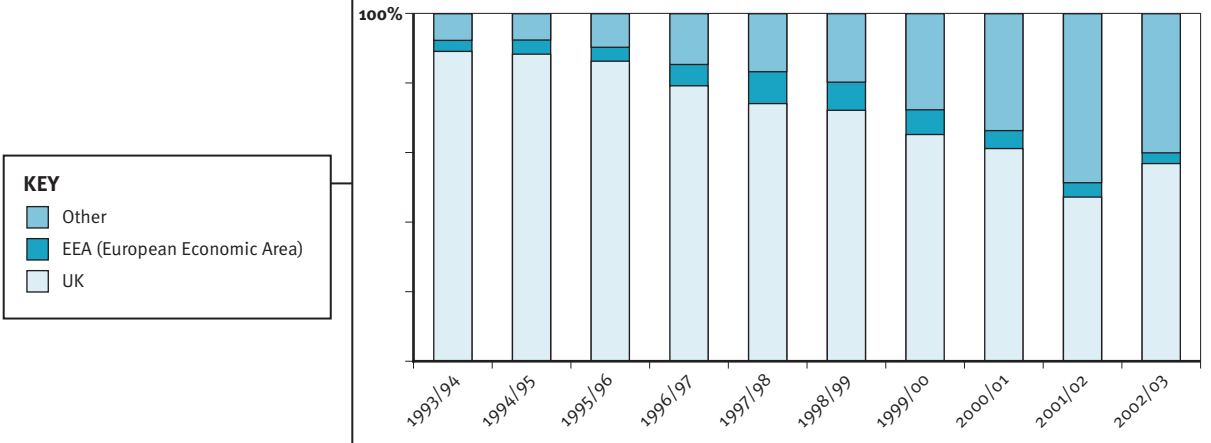


The current ‘stock’ of international doctors in the UK is significant. The Department of Health reports that about one in three of the 71,000 hospital medical staff working in the NHS in England in 2002 had obtained their primary medical qualification in another country.⁵ Many are in training grades, and two-thirds of ‘staff grade’ (that is to say, non-consultants) and associated specialists are from non-European Economic Area (EEA) countries.

Nurses

There has also been a significant increase in the number of nurses coming to work in the UK since the mid 1990s. This is highlighted in both registration and work permit data (see Figure 2). In 2002/03, approximately 43% of new nurse registrants in the UK were from abroad. Over 27,000 work permits were issued to nurses in 2003, compared with 14,000 in 2000.⁶ The main source countries for nurses in recent years have been the Philippines, South Africa, Australia and India.

2 NURSES: PERCENTAGE OF NEW FULL ENTRANTS TO NMC (UK) REGISTER FROM UK TRAINING, EEA COUNTRIES AND OTHER COUNTRIES, 1993–2003



The vast majority of international nurses who have arrived in London in the last eight years are from just six countries – the Philippines, South Africa, Australia, New Zealand, Nigeria and Ghana.

The dynamics of international recruitment of health professionals to the UK may change again as the first of the new accession states in Eastern and Southern Europe have now joined the EU. These countries include Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. There is potential to recruit from the accession states in Eastern Europe because the disparity in wage levels between these states and Western European countries is so great – this factor already stimulates recruitment from developing countries such as South Africa, India and the Philippines. Generally it is younger and better qualified individuals in the EU accession states who are reported to be the most likely to decide to migrate.⁷

The London picture

In this section we present initial findings about one key group of health workers – internationally qualified nurses – who are living in the capital. We then go on to examine the approaches to and experiences of international recruitment by three London NHS trusts.

London has a significantly higher proportion of internationally qualified nurses than the rest of the UK. The annual survey of Royal College of Nursing (RCN) members in 2003⁸ found that 14% of nurses based in London had qualified outside the UK – compared with just 4% in the UK as a whole. Data from the Nursing and Midwifery Council (NMC) highlight that more than 9,000 international nurses based in London in 2004 first registered in the UK in the last eight years (see Figure 3). Of these, over three-quarters are from just six countries – the Philippines, South Africa, Australia, New Zealand, Nigeria and Ghana.

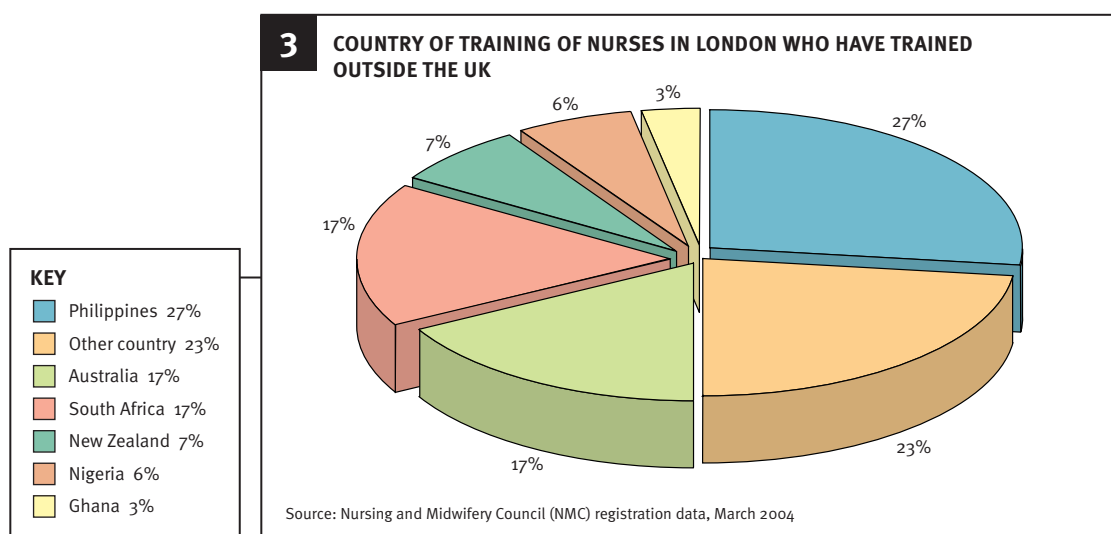
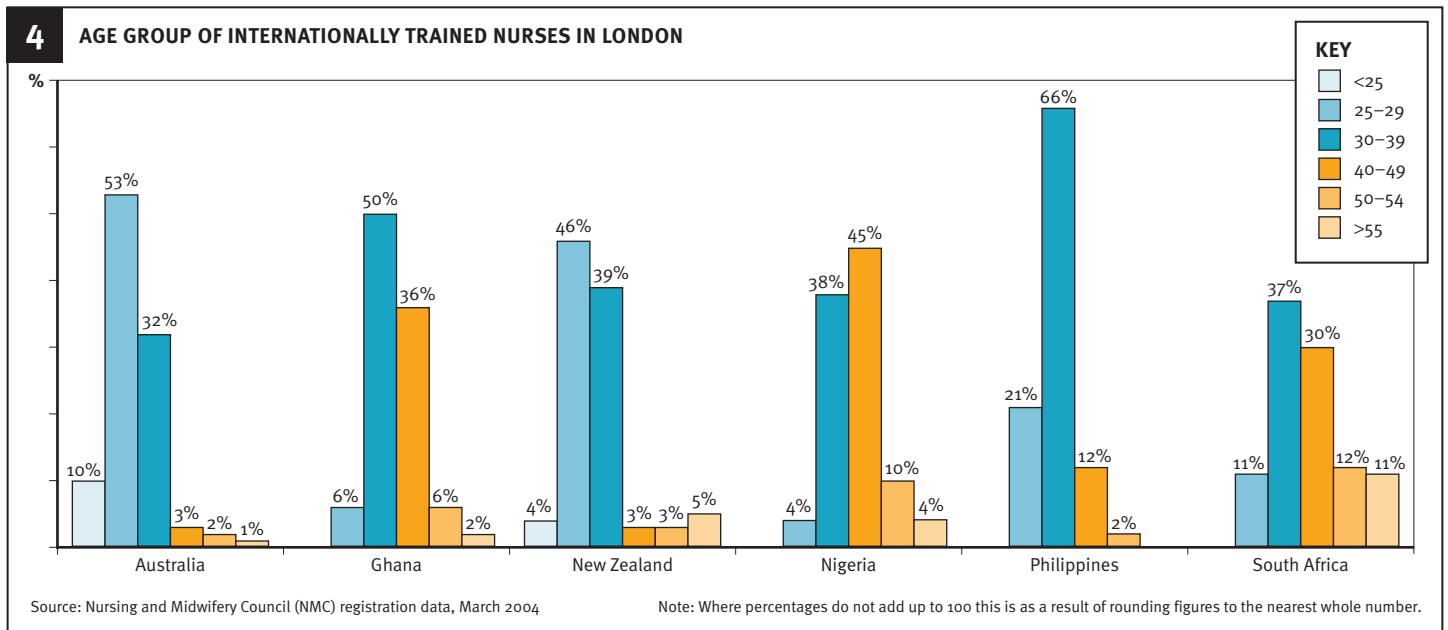


Figure 4 compares the age profiles of internationally recruited nurses from the 'top six' countries. About half of all nurses from Australia and New Zealand are aged between 25 and 29. The nurses who have registered in recent years from Ghana, Nigeria, the Philippines and South Africa are more likely to be in their 30s or 40s.



Case studies from three London trusts

Data from three London NHS trusts (shown as Trust X, Y and Z) provide more detail on the international recruitment activities and the level of reliance on internationally recruited staff. These are illustrative examples; the use of recruits from abroad varies significantly across different NHS trusts and other health care employers in the capital. We looked at three main questions:

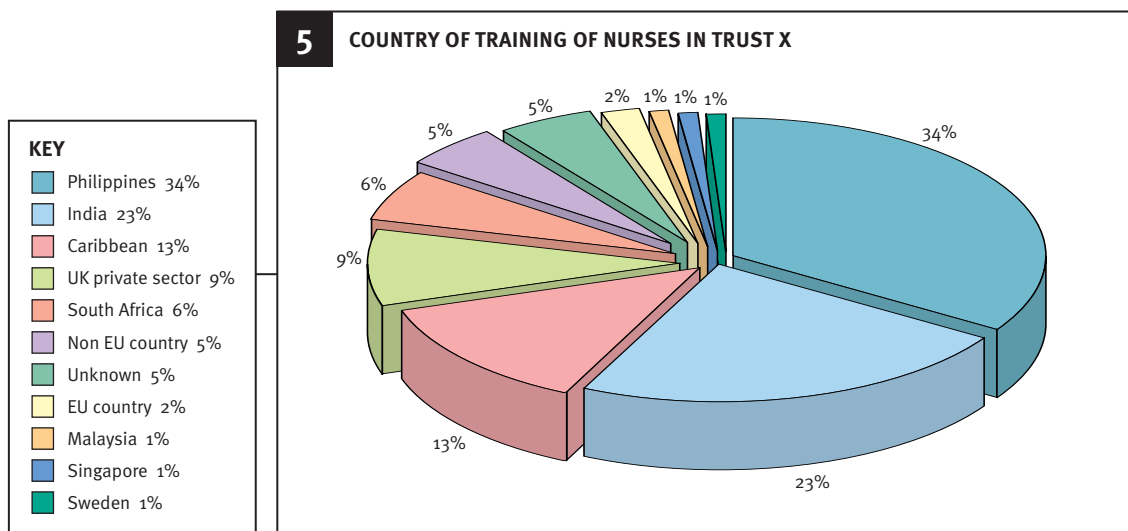
NHS trusts do not record their employment of international nurses in any standard format. This is a critical limitation in trying to assess the impact of, and reliance on, international recruitment in London.

How many nurses are there in these NHS trusts and where are they from?

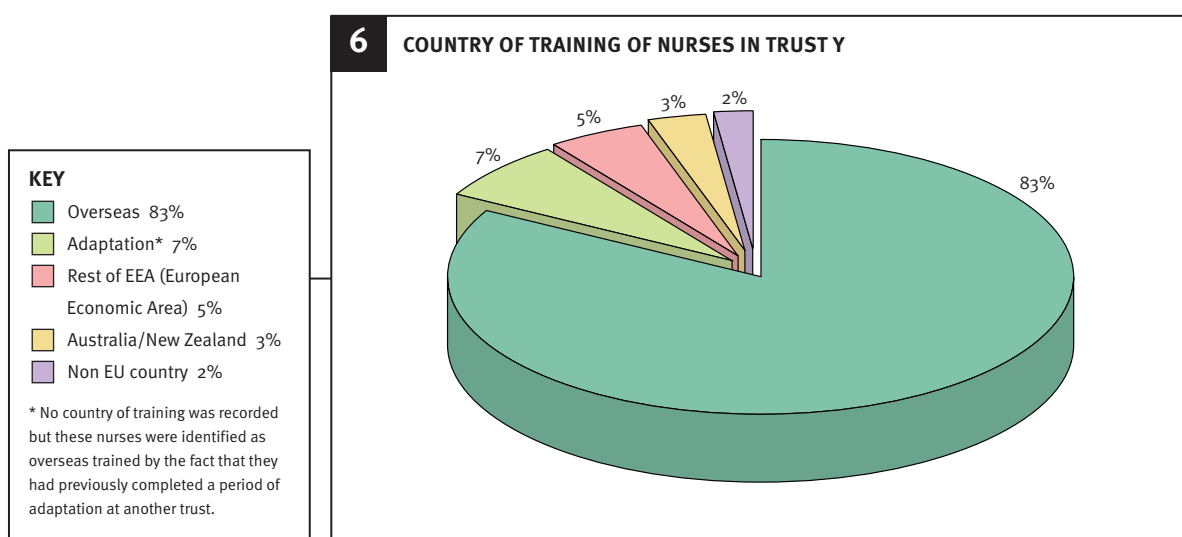
The three London trusts vary in size and structure, employing between 700 and 2,250 nurses. NHS trusts do not record their employment of international nurses in any standard format. This is a critical limitation in trying to assess the impact of, and reliance on, international recruitment in London. The estimated proportion of internationally qualified nurses in the three trusts was 12% of the qualified nursing workforce in Trust X, 15% in Trust Y and 25% in Trust Z. The majority of overseas-trained nurses were from

The estimated proportion of internationally qualified nurses in the three trusts was 12% of the qualified nursing workforce in Trust X, 15% in Trust Y and 25% in Trust Z.

the Philippines, Australasia, India, Ghana and Nigeria, confirming the NMC data. Seventy per cent of international nurses in Trust X trained in either the Philippines, India or the Caribbean (see Figure 5). Other reported source countries included South Africa, Sweden, Singapore, Malaysia and European countries outside the EU. The trust also reported that one in ten of these nurses had been recruited from the private sector in the UK, rather than direct from the source country.

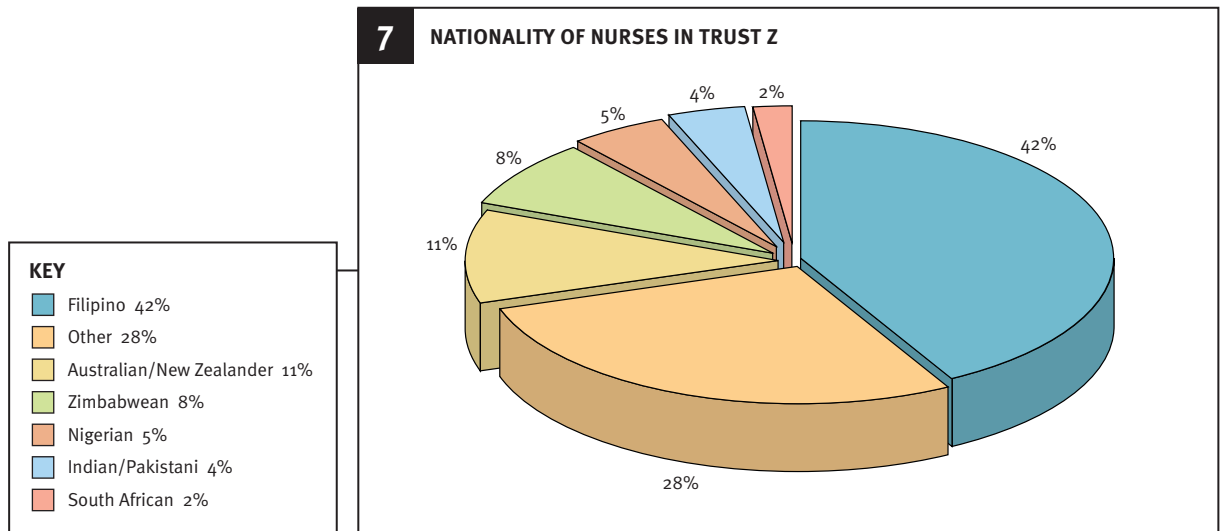


Trust Y reported that the majority (83%) of international nurses had been trained in countries outside Europe and Australasia (see Figure 6).



Information on the country of training is not routinely collected for Trust Z, so 'nationality' of nurse was used instead. (It is important to note that some

'non-UK' nurses may actually have been trained in the UK.) Almost half of the international staff in Trust Z are from the Philippines, followed by 11% from Australia and New Zealand, and 8% from Zimbabwe (see Figure 7).



These findings illustrate that NHS trusts in London are employing a high number of nurses from a broad range of countries – Trust Z, for example, has nurses from a total of 39 different nationalities working within it. This presents a double challenge: how to manage a diverse workforce and how to retain a high level of geographically mobile staff. The results also show that many trusts in London are employing nurses from developing countries that are reporting low levels of nursing staff, such as South Africa, Zimbabwe and Nigeria. In response to concerns about the impact of international recruitment, the Department of Health has issued a Code of Conduct requiring NHS trusts not to actively recruit from developing countries.

Why did the trusts choose to recruit internationally?

Responses from managers in the three London NHS trusts highlight that the main reason for recruiting abroad was the difficulty in recruiting at home.

Before recruiting internationally, Trust X reported that it had significant vacancies. It decided to recruit for general nursing posts as there were reportedly some concerns about the appropriate levels of experience of internationally recruited nurses to fill specialist posts. The trust has undertaken two trips overseas to recruit actively – the first to India in 1999 and the second to the Philippines in 2001.

Trust Y reported that it had significant vacancies at nursing grades 'D' and 'E' before recruiting internationally. Active international recruitment was used to fill these gaps, beginning in 2001 with two recruitment drives in the Philippines and one in Spain. Other internationally trained nurses were also employed from countries such as Jamaica and Australia, although these were 'passively' recruited as they arrived unsolicited.

Many trusts in London are employing nurses from developing countries that are reporting low levels of nursing staff, such as South Africa, Zimbabwe and Nigeria.

Managers in the trusts report that successful recruitment and effective integration involves good preparation before the international nurses' arrival, and continued support when they are at work.

Before international recruitment, Trust Z had significant vacancies at the more advanced 'E' grade posts but enough nurses at the lower 'D' grade posts. Active recruitment abroad was therefore used to tackle vacancies systematically at the higher grades, in particular in theatres and the Intensive Care Unit where vacancy rates and the associated agency costs were highest. There were three recruitment drives to the Philippines – one in 2001 and a further two in 2003.

All trusts highlighted similar reasons for their decision to recruit from specific countries. The Philippines was the most common country from which all the trusts had actively recruited. The most frequently cited reasons for recruiting from there was the belief that there was a 'plentiful supply of qualified nurses in the Philippines' and the fact that the Philippines was exempt from the Department of Health's list of countries that should not be targeted for recruitment.⁹

How successful has international recruitment been?

The three trusts cited the recruitment of staff to unfilled posts as the main marker of success – along with retention, this was seen as more important than any cost-benefit analysis of international recruitment as a whole. Trust X reported that, of those nurses who had been actively recruited, only about 10% had left, and Trusts Y and Z both reported that they no longer had vacancies for basic-level nursing posts that were previously difficult to fill.

'Successful' recruitment also involves the effective integration of internationally recruited staff into the system and culture of the organisation. Trust X reported that nurses who had recently arrived from the Philippines required additional support to work in a cultural and care environment very different to the one that they left behind at home – for example, they were initially regarded as being less assertive in communicating with other health professionals than UK-trained nurses. Managers at one trust also highlighted that there had been a perception of favouritism among some existing members of staff, who became resentful of some overseas staff being promoted above them.

Managers in the trusts report that successful recruitment and effective integration involves good preparation before the international nurses' arrival, and continued support when they are at work. Trust X employed a Filipino liaison officer to give emotional and practical support to all Filipino nurses as soon as they arrived in the UK. Trust Z set up regular consultations with overseas nurses to evaluate their progress and to get feedback on their experiences at work.

Managers in Trusts Y and Z both report that international recruitment has been successful in filling the staff shortages in basic-level nursing posts. However, high vacancy rates at higher 'F' grade posts, and particularly in midwifery, still remain. For this reason both trusts are likely to undertake further international recruitment, although with a more targeted and systematic focus on experienced staff for key nursing and midwifery posts.

Trust X, by contrast, does not plan any more active overseas recruitment. For basic-level nursing posts it has many local nursing students wanting to work at the trust from linked universities, and for the higher-level posts where there are still vacancies, the trust wishes to focus on ‘pulling people up through the ranks’. Managers reported that for long-term sustainability the trust will need to look to ‘grow its own’ and focus on developing supportive HR strategies as an effective employment strategy.

Key challenges

Examination of the London case studies and the data on the increase in recruitment of international health professionals emphasises three key challenges to the development of London’s health care workforce:



Supporting a diverse workforce

International recruitment requires a strong support and development infrastructure for both the staff coming from overseas and the existing staff within health care organisations. Our initial research shows that overseas staff in London come from a wide range of countries, some of which are significantly different from the UK in terms of culture, professional education and health systems organisation. Providing support for effective teamwork from an interdisciplinary, international and cross-cultural group of health professionals will be a critical success factor for the NHS in London.



Competing internationally

London is more reliant than the rest of the UK on international health workers and, as such, is more vulnerable to these workers leaving the UK. Alongside the challenge to develop effective human resources strategies to support and integrate these staff within the NHS, will be the challenge to retain these staff as other countries seek qualified health care staff to boost their own workforces. The main competitor in the English-speaking world is the United States, where more than three million extra jobs will be needed in the health sector by 2010.¹⁰ Likewise, Canada and Australia are also becoming more active in recruiting in global markets. Sustained use of good employment practices that encourage staff to stay in, and return to the NHS, and the recruitment of new workers from local sources as part of a ‘grow your own’ strategy will help limit the outflow of staff to other countries. Harnessing the skills of refugees, who make up a distinct population within the international workforce and are less mobile, may also provide a longer-lasting solution to the challenges of London’s dynamic health workforce.

Harnessing the skills of refugees may also provide a longer-lasting solution to the challenges of London’s dynamic health workforce.

London will have to ensure that it maintains an ethical balance between supporting the rights of individual health workers to move to improve their careers, and the potential negative impact on source countries in the developing world.

→ Recruiting ethically

International recruitment has moved from being a ‘quick fix’ to becoming a critical and integral part of the overall approach to meeting NHS staffing targets in London. However, one country’s policy solution may become another’s problem. There have been increasing reports about the negative impact of international recruitment on some of the main ‘source’ countries, particularly in sub-Saharan Africa.¹¹ The ethical dimension of the migration of health professionals has become a significant feature of health policy debate in the UK and elsewhere, and continues to cause controversy.^{12 13 14 15} The pressure is now on the UK and other developed countries to comply with international codes of practice on international recruitment. The UK has not signed the code introduced by the Commonwealth,¹⁶ but it will have to take account of the recent World Health Assembly (WHA) resolution requiring a more managed global approach to international recruitment.¹⁷ London remains a major destination for internationally recruited health workers so it will have to ensure that it maintains an ethical balance between supporting the rights of individual health workers to move to improve their careers, and the potential negative impact on source countries in the developing world.

Conclusion

How staff have arrived and what has motivated them to come to the UK is vital to understanding how appropriate policy should be developed to enable them to function effectively in the UK. Entry routes can vary significantly – from those on working holidays, to those who first came to the UK as refugees – and the support and developmental systems that are introduced will need to reflect this. Motivations and entry routes will also have important implications for the retention of staff in the face of international competition. It is clear that those workers who are internationally mobile and not seeking permanent residential status will be more susceptible to recruitment abroad. An Australian ‘backpacking’ physiotherapist may have different motivations and needs from a Filipino nurse who is looking for longer-term career stability. Both are likely to have different aspirations and priorities from, for example, a refugee Iraqi doctor. All, irrespective of source country, should have an equal right to exercise freedom of mobility; however, they should all also have an expectation of equal treatment in ethical recruitment and employment practices.

Next steps

The next stage of our research, to be published early in 2005, will provide more detailed information on the motivations, experiences and career plans of internationally recruited health workers currently working in London. We will also be reviewing and updating our original report on London’s health labour market, *In Capital Health?: Creative solutions to London’s NHS workforce challenges*, in the late Autumn 2004.¹⁸

References

- 1 Department of Health (2000). *The NHS Plan*. London: The Stationery Office.
- 2 Department of Health (2004). *International Medical Recruitment for NHS Employers*. London: Department of Health. Available at:
http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/MoreStaff/InternationalRecruitmentNHSEmployers/MedicalRecruitmentArticle/fs/en?CONTENT_ID=4044691&chk=/P3K3O
- 3 Department of Health (2001). *Code of Practice for NHS Employers Involved in the International Recruitment of Healthcare Professionals*. London: Department of Health. Available at:
http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/MoreStaff/InternationalRecruitmentNHSEmployers/CodeOfPracticeArticle/fs/en?CONTENT_ID=4043625&chk=D2OJCV
- 4 Greater London Authority (2002). *Missed Opportunities: A skills audit of refugee women in London from teaching, nursing and medical professions*. London: Greater London Authority.
- 5 Department of Health (2003). 'Hospital, Public Health Medicine and Community Health Services Medical and Dental Staff in England: 1992–2002' in *Statistical Bulletin 2003/04*. London: Department of Health.
- 6 Hansard (23 February 2004). Column 254W. London: The Stationery Office.
- 7 Krieger H (2004). *Migration Trends in an Enlarged Europe*. Dublin: European Foundation for the Improvement of Living and Working Conditions.
- 8 Ball J, Pike G (2003). *Stepping Stones: Results from the RCN membership survey 2003*. London: Royal College of Nursing. Available at: <http://www.rcn.org.uk/publications/pdf/membersurvey2003.pdf>
- 9 Department of Health (2001). *List of Countries*. London: Department of Health. Available at:
<http://www.dh.gov.uk/assetRoot/04/03/46/79/04034679.pdf>
- 10 Martiniano R, Salsberg E, McGinnis S, Krohl D (2004). *Health Care Employment Projections: An analysis of bureau of labor statistics occupational projections, 2002–2012*. New York: Center for Health Workforce Studies, University at Albany, School of Public Health.
- 11 see, for example, Dumont J, Meyer J (2004). 'The international mobility of health professionals: an evaluation and analysis based on the case of South Africa' in *Trends in International Migration*. Paris: Organisation for Economic Co-operation and Development.
- 12 Pang T, Lansang M, Haines A (2002). 'Brain drain and health professionals'. *British Medical Journal*, vol 324, pp 499–500.
- 13 Stilwell B, Diallo K, Zurn P et al (2003). 'Developing evidence based ethical policies on the migration of health workers: conceptual and practical challenges'. *Human Resources for Health*, vol 1, p 8.
- 14 Buchan J (2004). 'International rescue? The dynamics and policy implications of the international recruitment of nurses to the UK'. *Journal of Health Services Research and Policy*, vol 9, no 1 (supplement), pp 10–16.
- 15 Scott M, Whelan A, Dewdney J, Zwi A (2004). 'Brain drain or ethical recruitment?'. *Medical Journal of Australia*, vol 180, no 4, pp 174–176.
- 16 Available at: http://www.thecommonwealth.org/shared_asp_files/uploadedfiles/%7B7BDD970B-53AE-441D-81DB-1B64C37E992A%7D_CommonwealthCodeofPractice.pdf
- 17 World Health Assembly Resolution. Available at:
http://www.who.int/gb/ebwha/pdf_files/WHA54/ea54r12.pdf
- 18 Buchan J, Finlayson B, Gough P (2003). *In Capital Health?: Creative solutions to London's NHS workforce challenges*. London: King's Fund.

King's Fund

11–13 CAVENDISH SQUARE
LONDON W1G 0AN
INFORMATION 020 7307 2568
SWITCHBOARD 020 7307 2400
www.kingsfund.org.uk

The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through grants. We are a major resource to people working in health, offering leadership and education courses; seminars and workshops; publications; information and library services; and conference and meeting facilities.

Registered Charity 207401