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Phoenix House  
Phoenix Lane  
Tiverton  
Devon  
EX16 6PP  
[www.middevon.gov.uk](http://www.middevon.gov.uk)

Contact: **Carole Oliphant**  
Telephone:  
:  
Email: **Coliphant@middevon.gov.uk**  
**01884 234209**

**Date 31<sup>st</sup> August 2018**

Dear Member

## **Scrutiny Committee 10<sup>th</sup> September 2018**

I am now able to enclose, for consideration at the next meeting of the **Scrutiny Committee**, the following reports that were unavailable when the agenda was printed.

To add to your agenda for the meeting.

### 10 **SCRUTINY OFFICER UPDATE** (*Pages 3 - 58*)

To receive a report from the Scrutiny Officer of topics that he had been tasked with.

Supplement; The Nursing Workforce Health Committee Report

Yours sincerely

**Carole Oliphant**  
Member Services Officer

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House of Commons  
Health Committee

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# **The nursing workforce**

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**Second Report of Session 2017–19**





House of Commons  
Health Committee

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# The nursing workforce

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## Second Report of Session 2017–19

*Report, together with formal minutes relating  
to the report*

*Ordered by the House of Commons  
to be printed 16 January 2018*

**HC 353**

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## Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health.

### Current membership

[Dr Sarah Wollaston MP](#) (*Conservative, Totnes*) (Chair)

[Luciana Berger MP](#) (*Labour (Co-op), Liverpool, Wavertree*)

[Mr Ben Bradshaw MP](#) (*Labour, Exeter*)

[Dr Lisa Cameron MP](#) (*Scottish National Party, East Kilbride, Strathaven and Lesmahagow*)

[Rosie Cooper MP](#) (*Labour, West Lancashire*)

[Dr Caroline Johnson MP](#) (*Conservative, Sleaford and North Hykeham*)

[Diana Johnson MP](#) (*Labour, Kingston upon Hull North*)

[Johnny Mercer MP](#) (*Conservative, Plymouth, Moor View*)

[Andrew Selous MP](#) (*Conservative, South West Bedfordshire*)

[Maggie Throup MP](#) (*Conservative, Erewash*)

[Dr Paul Williams MP](#) (*Labour, Stockton South*)

### Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via [www.parliament.uk](http://www.parliament.uk).

### Publication

Committee reports are published on the Committee's website at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom) and in print by Order of the House.

Evidence relating to this report is published on the [inquiry publications page](#) of the Committee's website.

### Committee staff

The current staff of the Committee are Huw Yardley (Clerk), Seth Roberts (Second Clerk), Laura Daniels (Senior Committee Specialist), Lewis Pickett (Committee Specialist), Juliette Mullin (Clinical Fellow), Cecilia Santi O Desanti, (Senior Committee Assistant), Ed Hamill (Committee Assistant), and Alex Paterson (Media Officer).

### Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is [healthcom@parliament.uk](mailto:healthcom@parliament.uk).

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## Summary

In too many areas and specialties, the nursing workforce is overstretched and struggling to cope with demand. Over the course of our inquiry, we heard concerns about the impact of these pressures on morale, retention, and standards of care for patients.

Major changes have recently been made to routes in to nursing. However, too little attention has been given to retaining the existing nursing workforce, and more nurses are now leaving their professional register than are joining it. There are many causes for the shortfall in the nursing workforce, including workload pressures, poor access to continuing professional development, a sense of not feeling valued, ongoing pay restraint, the impact of Brexit and the introduction of language testing.

Access to continuing professional development (CPD) was clearly a major issue and we recommend that the cuts to nurses' training budgets should be reversed and greater attention be given to ensuring nurses can access CPD. The Chief Nursing Officer should write to all Directors of Nursing asking for assurance that their nurses have time to carry out appropriate handovers, and to take their breaks; and that they have access to food and drink near their place of work.

The nursing workforce needs to be expanded at scale and pace. We heard a clear message about relentless pressures which, at their most extreme, meant that nurses felt their professional registrations were at risk because they were struggling to cope with demand. Without increasing the workforce, nurses will continue to experience unacceptable pressure, and their skills will continue to be lost to patients across the NHS and community settings.

We welcome the Government's development of new routes into nursing, including apprenticeships and the fast track Nurse First programme as well as the new Nursing Associate role. However, traditional three year nursing degrees remain the main route into nursing, and it is essential that the Government closely monitors the impact of recent changes to funding for nursing degrees. The Government must be prepared to act quickly if there are signs that numbers of nurses in training are declining.

In particular, we are concerned about the potential impact of these reforms on mature students, and on branches of nursing already experiencing shortages, such as learning disability and mental health nursing. We ask the Government to set out specifically how it plans to respond if these concerns are realised.

We welcome the new role of Nursing Associate, which has the potential to add further support for patient care and which adds diversity to the workforce as a route onwards for aspiring nurses for whom the traditional undergraduate route is not an option. It will enable Healthcare Assistants, who previously had few career progression options or opportunities for further training to become Nursing Associates (NAs) and if they so wish progress from there via the apprenticeship route into degree nursing. Nursing Associate is a role in its own right, not a substitute for registered nurses, and those undertaking this training deserve a clear professional identity of their own. We

recommend the development of a clear, plain English guide to this new role, which will be helpful for patients, the public, team members and employers alike, setting out NAs' scope of practice across a range of settings.

Nurses from across the EU working in the UK need and deserve further reassurance about their right to remain, following the vote to leave the EU. They need a clear message that they are welcome and appreciated and that they will be able to remain working as nurses in the UK.

The UK depends upon nurses recruited from overseas, and will do so for many years to come. Whilst recognising the need for communication skills, it is essential that changes to language testing for overseas nurses wishing to practice in the UK must be carefully and regularly monitored to ensure that they are not placing unnecessary barriers to UK practice. Overseas recruitment must continue to follow clear ethical principles, and we recommend that this should also be co-ordinated at a national level. Moreover, migration policy needs to ensure that the UK continues to have access to the nurses it needs. We call on the Home Office to extend the period that nurses are on the shortage occupation list.

We welcome Health Education England's decision to publish a draft workforce strategy and also to take a longer-term view. The Government and HEE must act to ensure that reliable data is available from across all sectors to inform workforce planning. Moreover, future projections of demand for nurses should be based on demographics and other demand factors, rather than on affordability.

Pay restraint is a factor in the recruitment and retention challenge and we welcome the announcement that the cap has been lifted as well as reassurance that funding for the rises will not come out of existing NHS budgets. We caution that linking productivity to any pay rises must be realistic and recognise the existing pressures on, and productivity gains by, the nursing workforce.

## The current situation

1. In too many areas and specialties, the nursing workforce is overstretched and struggling to cope with demand. Over the course of our inquiry, we heard concerns about the impact of these pressures on morale, retention and standards of care for patients and patient safety.

### The following data gives an indication of nursing workforce numbers:

There is no agreed measure of the shortfall in the nursing workforce in England. Health Education England state that there are 36,000 nursing vacancies in the NHS in England, equating to a vacancy rate of 11%,<sup>1</sup> while the Royal College of Nursing give a figure of 40,000.<sup>2</sup> There is a 9% nursing vacancy rate in social care.<sup>3</sup>

Vacancy rates mean that posts are not substantively filled, but they may be being filled by bank or agency staff on a temporary basis. HEE estimate that 33,000 of the 36,000 nursing vacancies in the NHS are being filled by bank or agency staff<sup>4</sup> This leaves an overall rate of posts wholly unfilled of around 3,000 (1%).

Vacancy rates differ between nursing specialties – learning disabilities nursing is the specialty with the highest vacancy rate at 16.3%, followed by mental health (14.3%) children's nursing (10.9%) and adult nursing (10.1%)<sup>5</sup> The community nursing vacancy rate is estimated at 9.5%.<sup>6</sup>

Vacancy rates also differ by geographical area. For adult nursing, the highest vacancy rate, 15.7%, is in South London; the East of England has a vacancy rate of 13.4%; the East Midlands 10.1%; and the North East is the lowest at 8%.<sup>7</sup>

This significant vacancy rate has in part been driven by the NHS's response to the public inquiry into poor care at Mid-Staffs, following which many new nursing posts were created, but without a matching supply of new nurses to fill them.

Since 2010 there has been a 1% increase in nurses and health visitors working in the NHS (1,653); however, the increase in nurses has not kept pace with the increase in doctors (12%), consultants (27%) or the population (5.7%).<sup>8</sup> There has also been an increase in the complexity and severity of the conditions for which people are receiving treatment in the NHS. It is a tribute to the success of public health and the NHS that people are living longer but many more of us are living with multiple long term conditions.<sup>9</sup>

The UK has fewer nurses relative to the population than the OECD average, and it is also below many EU countries and traditional comparator countries.<sup>10</sup>

1 Q289; Q245 - based on NHS Improvement analysis of trust data

2 Royal College of Nursing ([NWO0113](#)) para 2.7

3 Skills for Care ([NWO0091](#)) para 1.7. This covers nurses working in care homes with nursing services (88% of social care nurses) in domiciliary care services (7%) and the remaining 5% in other services<sup>2</sup>. The vast majority of nurses in the sector work for the independent sector, with only an estimated 200 nurses (0.7%) directly employed by local authorities.

4 Q289

5 Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), December 2017; p106

6 Figure supplied by HEE

7 Vacancy rates as at March 2016. Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), December 2017; p26

8 Royal College of Nursing ([NWO0113](#)) para 2.5; population increase is an estimated figure based on ONS data

9 Care Quality Commission, [The state of health care and adult social care in England, 2016/17](#), October 2017; p8

10 Health Foundation, [Rising pressure: the NHS workforce challenge](#), October 2017; pp25–27

There is also great variation between sectors. Most of the increase in nurses since 2010 has been in the adult acute sector, with many other sectors experiencing significant reductions:

+7% (+11,983) in general, elderly and adult nurses

+10% (+1,468) in children's nurses

+11% (2,056) in midwifery

-11% (-4,985) in community services<sup>11</sup>

-45% (-3,431) in district nurses

-19% (-554) school nurses

-38% (-2,023) across all learning disabilities settings and

-13% (-5,168) across all mental health settings.<sup>12</sup>

Turnover (nurses moving between different NHS organisations) has also increased from 12.3% in 2012–13 to 15% in 2016–17.<sup>13</sup>

The total number of nurses working in the NHS fell by around 1,000 in the year June 2016– June 2017.<sup>14</sup>

Increasing numbers of UK nurses are leaving the profession each year.<sup>15</sup> Just over 29,000 UK nurses and midwives left the NMC register in 2016–17, up 9% from the previous year. <sup>16</sup>Around 33% of these were over 60.<sup>17</sup>

In recent years this has been partially offset by increases in EU nurses working in the UK, but this trend has been reversed in the past year. In 2016–17, 1,107 people from the EEA joined the NMC register, an 89% drop on the previous year, and 4,067 left the register, an increase of 67%. The total number of EEA professionals on the NMC register has decreased by 2,733 in the past year.<sup>18</sup>

11 Community nurses includes district nurses, and other community nurses employed directly NHS trusts or CCGs, It does not include practice nurses.

12 All figures are from May 2010 - May 2017. Source - NHS Digital, cited from NHS Indicators: England, October 2017, [Briefing Paper 7281](#), House of Commons Library, October 2017; p18

13 Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), December 2017; p44

14 Figures are Full Time Equivalent (FTE). *NHS Indicators: England, October 2017*, [Briefing Paper 7281](#), House of Commons Library, October 2017; p17

15 In their publication [The NMC register 2012/13 - 2016/17](#), the NMC state that "it should be noted that as the number of people on the register had increased by several thousand a year until 2016/2017, it is to be expected, to a certain extent that the overall numbers leaving will have increased."

16 Nursing and Midwifery Council, [The NMC register, 30 September 2017](#), November 2017.

17 Percentage of leavers in age 61 and above age categories calculated by NMC for Committee

18 Nursing and Midwifery Council, [The NMC register, 30 September 2017](#), November 2017

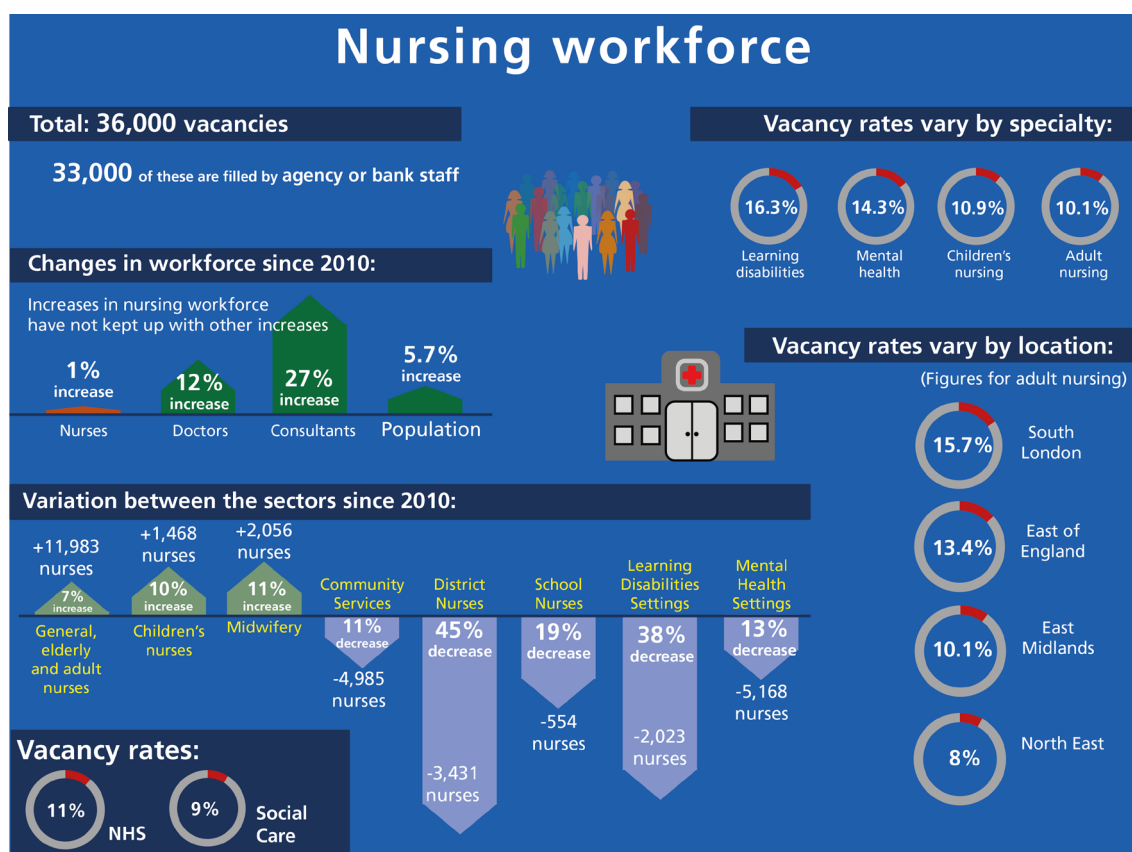
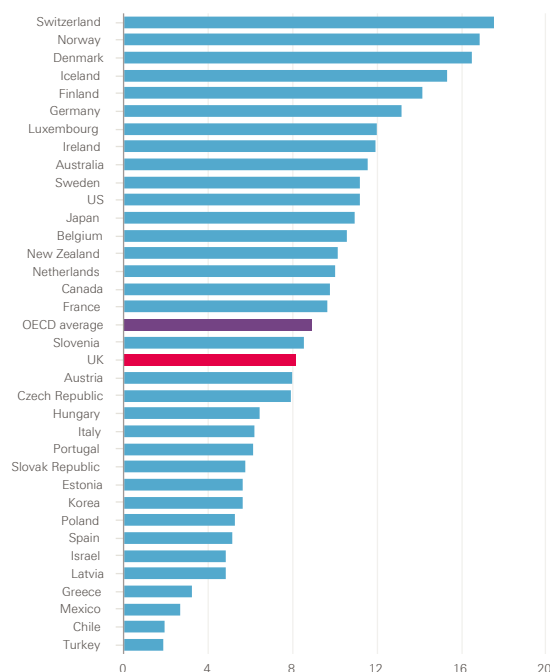


Figure 12: Number of nurses per 1,000 population in OECD countries, 2014 (or nearest year)



Source: OECD Health statistics 2017 (database), Health care resources.

2. Witnesses to our inquiry told us that there is currently a crisis in the nursing workforce.<sup>19</sup> However, disentangling the causes, and possible solutions, is challenging because of the rapidly changing training and professional landscape.

3. 2017 has seen major changes to the routes into nursing, with the removal of bursaries and the introduction of nursing associates and nursing apprenticeships. The UK's decision to leave the EU, alongside changes to language testing, have also made an impact on recruitment and retention. We welcome the Government's decision to publish its Workforce Strategy in draft form, for consultation, and call on the Government to take full account of our recommendations in its final Workforce Strategy which is due to be published in July this year.

4. Issues relating to the nursing workforce span many different but interrelated organisations. But as well as meeting representatives from national organisations, we were particularly keen to hear directly from nurses working at the front line. Therefore, with the help of the *Nursing Times*, we held two focus groups where we met with nurses from across the country, from a wide range of specialities and at different stages of their careers. The Chair, representing the Committee, met with two nursing focus group at a national team leaders' conference held in Birmingham.<sup>20</sup> The Committee heard from a further focus group of nurses from across the country at its visit to the Royal London Hospital.<sup>21</sup> We also heard from trainees in the new nursing associate role as well as those involved in teaching them.<sup>22</sup> We are extremely grateful to everyone who contributed to this inquiry, but in particular to those individual professionals who spoke to us so thoughtfully and frankly about their work.

5. We heard evidence that nursing shortages are now having a negative impact on the quality and safety of patient care within both community and hospital settings.<sup>23</sup>

6. The potential impact of staffing levels on safety was clearly articulated by Sir Robert Francis QC, Chair of the Mid Staffs inquiry and Honorary President of the Patients' Association, at the Committee's first session:

Nurses are the glue that keeps together delivery of the service to patients. If you do not have sufficient numbers of caring and compassionate nurses, the patient and perhaps their relatives begin to suffer immediately—there is no one to undertake observations, changes in which tell doctors what treatment is needed. Deteriorations are missed and patients who cannot care for themselves in the most basic ways are left uncared-for.<sup>24</sup>

7. Written evidence from the Care Quality Commission also raised safety concerns relating to nursing shortages:

Across all health and adult social care settings we are concerned about the shortage of nurses and the impact this is having on the people using those services ... Common issues we have identified where there is a shortage of staff relate to inconsistent identification and management of life threatening

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19 Q1 (Sir Robert Francis QC); Q98 (Jackie Smith, Chief Executive, NMC)

20 Annex 1

21 Annex 2

22 Annex 2

23 Annex 1 and 2; here, term 'community' includes community nurses and primary care nurses.

24 Q2

conditions such as sepsis; incomplete, inconsistent and ineffective audits of key safety priorities and quality improvement projects; poor infection control procedures, including hand hygiene and isolation practices; staff not receiving essential safety training including appropriate safeguarding training; insufficient record keeping, and poor sharing of information—leading to incomplete care plans and tests and treatments being delayed or repeated unnecessarily. Although these issues are not entirely due to a shortage of nursing staff, the overall impact of staff shortages on a clinical team is that these issues occur all too frequently. We are also concerned that some Healthcare Assistants are being asked to carry out tasks which they are not qualified for, and in some cases are actually being called nurses.<sup>25</sup>

8. Working in teams that are short staffed also has a negative impact on nurses, affecting their own safety and wellbeing, as well as eroding their pride in their role. During the focus groups in Birmingham, the Chair heard a simple and clear message—nurses working in all sectors need “more hands on deck”.<sup>26</sup>

9. Nurses are clearly concerned that the increasing pressure is having an impact on their ability to deliver safe care. They bear personal responsibility for the delivery of that care. Speaking at one of our informal meetings with nurses, one nurse articulated this concern very clearly, telling us of her fears for her professional registration, “every time I walk onto the ward, my PIN is on the line”.<sup>27</sup>

10. The increasing demand for health services is well documented.<sup>28</sup> Nurses in our focus groups described caring for people living with increasingly complex and serious conditions and the difficulties they face when workload pressures make it impossible to deliver optimal patient care.<sup>29</sup>

11. Following the Francis report, there was a justified drive to increase nursing staff numbers in acute trusts. However, we heard that this may have drawn nurses away from community and social care services, and that both community nursing and social care nursing services are overstretched.<sup>30</sup> Numbers of general, adult and elderly nurses have increased by 7% since 2010, and children’s nurses by 10%, but over the same period community nurse numbers have fallen by 11%.<sup>31</sup> This imbalance runs directly against moves to shift more care out of hospitals and into the community.

## The current situation: summary

12. The nursing workforce needs to expand at scale and pace in order to provide high quality care, meet rising demand and reduce unacceptable pressures on existing staff.

13. There are particularly worrying shortfalls in certain sectors—district nursing and in nursing homes, mental health and learning disability nursing.

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25 Care Quality Commission ([NWO0110](#)) pp4–5

26 Annex 1

27 Annex 1. A nurse’s PIN number is his or her professional registration number, provided by the NMC, which entitles them to practice as a registered nurse.

28 See, for example, King’s Fund, [How hospital activity has changed over time](#), December 2016

29 Annex 1, Annex 2

30 Q17; Annex 2.

31 Figures are from May 2010 - May 2017. Cited from NHS Indicators: England, October 2017, [Briefing Paper 7281](#), House of Commons Library, October 2017, p18



14. We welcome the diversification of the nursing workforce, both in the development of specialist roles and in new opportunities for Health Care Assistants to be able to train as Nursing Associates and, through the apprenticeship route, to be able to study for a nursing degree. The major route into nursing, however, remains the full time university degree and there are worrying signs that the removal of the bursary is having a negative impact on applications from mature students.

15. Whilst training new nurses is important, there has been a loss of focus on retaining the current workforce. The Government must pay greater attention to making nurses feel valued and to improving morale. We welcome the indication that the pay cap has been removed but the government should also reverse the cuts to nurses' CPD. We turn in more detail to these issues in the following chapters.

# 1 Retention—keeping the current workforce

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## Introduction

16. Growing numbers of UK trained nurses are leaving the profession—around 29,000 UK nurses and midwives (5%) left in 2016–17, up from just under 21,000 (3.6%) 2012–13.<sup>32</sup> Around 33% of those who left in the past year were over 60 years of age.<sup>33</sup> Figures show that the percentage of nurses leaving the NHS has also increased over that period.<sup>34</sup> Since 2012–13, 8,000 nurses have left social care.<sup>35</sup>

17. Health Education England told us that “if we had kept the 2012 retention figure right the way through, we would have 16,000 more nurses now than we do at the moment, which is about 50% of all the vacancies we have in the NHS. These numbers are very large”.<sup>36</sup> However, most Government policy has focused on increasing the number of new nurses, rather than working to retain existing nurses. It takes at least three years to train a new nurse, meaning that the Government’s new routes into nursing may help in the medium and long term, but will not address the immediate nursing shortage. Unless pressures are addressed, we also know that there is a greater chance that more of these newly qualified nurses will leave.<sup>37</sup> There needs to be a greater focus on retaining the current nursing workforce.

## Why do nurses leave?

18. The nurses we met described nursing as a rewarding, fulfilling and dynamic career, full of possibilities - in the words of one nurse, “the world is your oyster”. They described colleagues as ‘doing an incredible job’, all with immense “cheer and care and kindness”.<sup>38</sup> However, despite their clear and undisputed value in all clinical settings—across the community<sup>39</sup> as well as hospitals and mental health services—nurses report that they do not feel valued. That needs to change.

19. Although not enough research has been done to understand why nurses leave nursing, difficult working conditions, exacerbated by staffing shortfalls, are likely to be playing a significant part. According to the Nursing and Midwifery Council (NMC) working conditions are a major factor in nurses leaving the profession.<sup>40</sup>

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32 Nursing and Midwifery Council, [The NMC register, 30 September 2017](#), November 2017. In their publication [The NMC register 2012/13 - 2016/17](#), the NMC state that “it should be noted that as the number of people on the register had increased by several thousand a year until 2016/2017, it is to be expected, to a certain extent that the overall numbers leaving will have increased.”

33 Percentage of leavers in age 61 and above age categories calculated by NMC for Committee

34 Department of Health ([NWO0089](#)) p9

35 Skills for Care ([NWO0091](#))

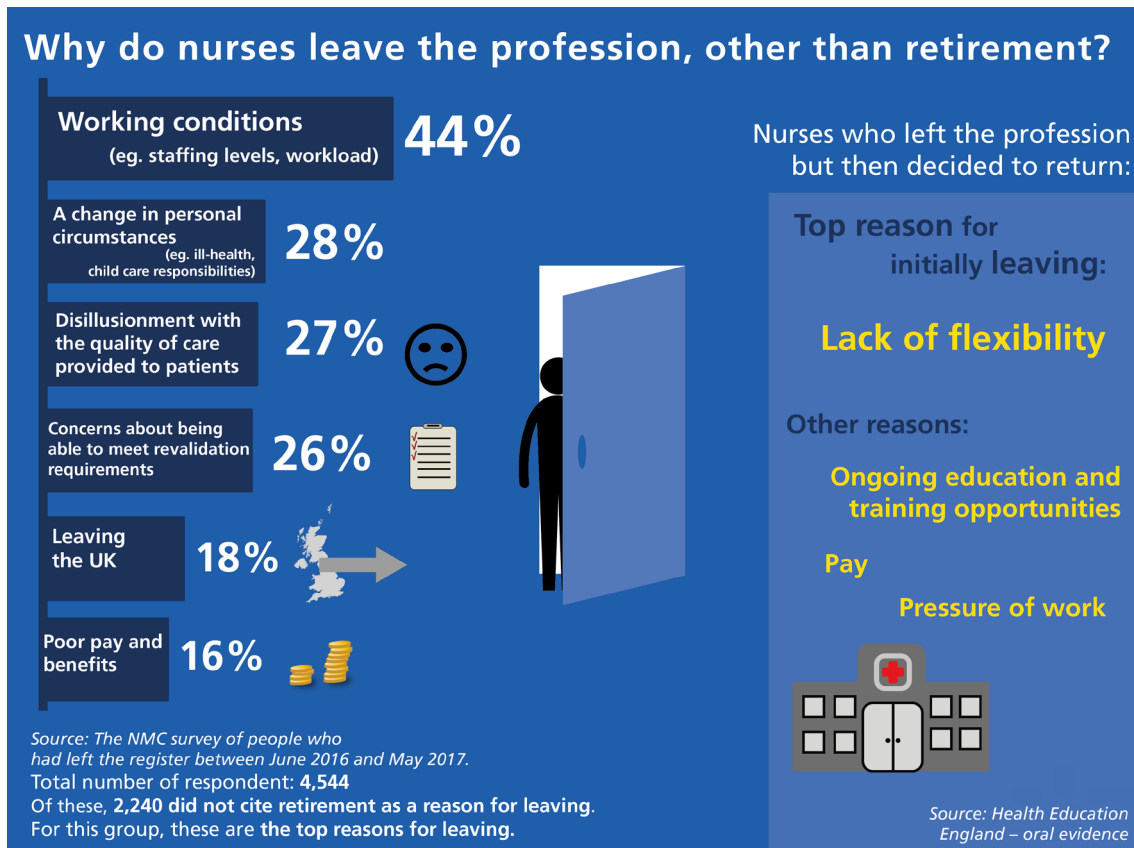
36 Q202

37 Annex 1

38 Annex 1

39 The term ‘community’ includes community nurses, district nurses, primary care nurses, and nurses working in social care settings.

40 Nursing and Midwifery Council, [The NMC register 2012/13 - 2016/17](#), July 2017, p9



20. Jackie Smith, Chief Executive of the NMC, told us:

The 4,500 who responded said that the issue for them was working conditions. That can encompass a lot of things. That is about staffing levels; about flexibility; about pay; and about not investing in their future. Cuts to CPD are a major issue. That's what I hear when I go around the UK. The nursing profession does not feel valued. What it does is not recognised sufficiently. For them they think "I may as well go elsewhere and do something else". That is tragic. That is not what we need.<sup>41</sup>

21. The Royal College of Nursing gave a similar assessment:

They feel that they are not valued ... there are not enough staff, you are not getting a pay rise, and your education budget is being cut. Every which way you look, everything that supports nurses has been reduced over time.<sup>42</sup>

22. For nurses returning to practice through Health Education England return to practice schemes, lack of flexibility was the top reason for initially leaving, for example to fit in with childcare or other personal circumstances.<sup>43</sup>

41 Q89  
42 Q46  
43 Q202

## Pay

23. We heard that ongoing pay restraint is having an impact on both recruitment and retention.<sup>44</sup> During the course of this inquiry, the removal of the pay cap for nurses has been announced, which we welcome.<sup>45</sup>

24. We were assured that additional funding above the 1% current cap will be provided separately from the existing Budget settlement for the Department of Health. The Government has said, however, that any future pay deal will be on the condition that the pay award enables improved productivity in the NHS.<sup>46</sup> NHS productivity is already higher than the background rate of the wider economy.<sup>47</sup> We urge the Government to come forward with realistic proposals as nursing is already an overstretched workforce, recommended in this pay review in full rather than expect the NHS to fund it from already overstretched resources.

25. It is essential that pay rises alone are not seen by Government as the sole solution to the problem of nurse retention, as we have heard in this inquiry that pay is only one element amongst many.

## Working conditions

26. During the focus groups with nurses in Birmingham, the Chair heard a clear message—nurses working in all sectors need “more hands on deck”.<sup>48</sup> As we have noted above, nurses are clearly concerned that the increasing pressure is having an impact on their ability to deliver safe care, for which they bear personal professional responsibility.

27. Staff shortages have been reported in RCN surveys,<sup>49</sup> and were described very clearly by nurses in our focus groups from across a wide range of settings and geographical areas.<sup>50</sup> HEE reports that most (92%) of the 36,000 nursing vacancies are filled by agency or bank staff, rather than actually being vacant.<sup>51</sup> However, agency staffing is not only costly, but can create other difficulties.<sup>52</sup> Some nurses prefer to carry out bank or agency work as it may give greater flexibility and higher rates of pay. This itself may be contributing to perceived staff shortages. Whilst bank staff allow some flexibility in meeting variations in demand, the priority, in order to provide the best standards of care and continuity, must be to recruit and retain permanent staff. Permanent posts must not be deliberately left vacant or recruitment delayed to ease financial pressures.

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44 Q46

45 HC Deb, 10 October 2017, [col 154](#) [Commons Chamber]

46 HM Treasury, [Autumn Budget 2017](#), p3

47 Centre for Health Economics, University of York, [Productivity of the English NHS: 2014/15 Update](#), April 2017, p48

48 Annex 1

49 Q14

50 Annex 1

51 Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), December 2017; p108

52 See for example Annex 1; Care Quality Commission ([NWO0110](#)) pp1–2

28. Nurses described often arriving early for shifts and finishing late, and not being able to take breaks because there are too few staff on duty.<sup>53</sup> The Royal College of Nursing argued that nursing shortages are impacting on handovers between nurses at the beginning and end of shifts, again potentially threatening the quality of care to patients.<sup>54</sup>

29. Nurses also told us that they lack even basic facilities on the wards where they work to prepare food and drink for themselves. The RCN explained, for example, that having food available in canteens that are a 10 minute walk from the ward where nurses are working is no good if the nurse's break is only 15 minutes long.<sup>55</sup> Nurses told us that even where some trusts do provide wellbeing initiatives, they struggle to find the time to attend.<sup>56</sup>

30. We also heard about these issues from independent commentators outside the nursing profession. Sir Robert Francis QC, Chair of the Mid Staffordshire inquiry and honorary President of the Patients Association, gave the following view:

A huge number of staff are working in, frankly, unacceptable and unsafe conditions. I believe that must impact particularly on nurses, because of their role in the front line, being professionally responsible for the standard of care delivered on a minute-by-minute basis to patients, allied sometimes to the feeling that they cannot do it—I have heard a lot about that—and the stress of not being able to deliver what a nurse or a professional knows should be delivered. That must make life impossible. That will discourage people from joining the profession. It will encourage people to leave it.<sup>57</sup>

31. We were concerned to hear that some nurses lack basic facilities during their breaks or even the time to take them and felt that they were not allowed to sit down and spend time talking to patients over a cup of tea. We believe there are times when this may enhance care and were reassured to learn from the Chief Nurse that there is no prohibition on this happening.<sup>58</sup>

## Reduction in funding for nurses' education and training

32. Our evidence argues that reductions in the availability of funding for continuing professional development (CPD) is a major issue contributing to nurses leaving the profession.<sup>59</sup> The budget for nurses' CPD has fallen from £205 million to £84 million in two years.<sup>60</sup>

33. NHS Employers highlighted this as a 'fundamental' priority for national action, arguing that "the level of disinvestment ... limits ... not just the opportunities for advanced practice, but a standard way of investing in the training of people to carry out the jobs they need to carry out, particularly in specialist settings such as intensive care and community settings".<sup>61</sup>

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53 Annex 1

54 Q34; Royal College of Nursing ([NWO0126](#))

55 Q34

56 Annex 1

57 Q9

58 Q247 - Q256

59 Q54; Q89;.

60 Royal College of Nursing ([NWO0113](#)) para 2.16

61 Q38

34. The RCN also raised this as a major issue:

I am talking to Directors of Nursing all the time, who are trying to get their nurses on an intensive care programme, or accident and emergency, or community providers who need someone to do the district nurse programme. There is no money for those programmes at the moment. It has been pretty much decimated.<sup>62</sup>

35. For nurses working in social care, the situation regarding access to continuing professional development is even worse.<sup>63</sup>

36. Nurses we spoke to in our focus groups felt that even if funding were available for their training, they were so busy they would be unlikely to be able to take time away to attend. One nurse told us “You are lucky if you can get released to go to a meeting, let alone a study day”.<sup>64</sup>

37. Health Education England told us that reducing nurses’ CPD funding had been a conscious decision taken in the context of the decision to invest in training more of the future workforce.<sup>65</sup> However, they indicated that they now intended to increase funding again for nurses CPD.<sup>66</sup> We would like to see evidence of a clear plan for reintroducing this.

### Further ways to improve retention

38. We heard that nurses want increased flexibility in the way they work. Staff shortages make it even harder to enable nurses to work flexibly.<sup>67</sup> We heard from the RCN that organisations could make far better use of tools like e-rostering.<sup>68</sup>

39. NHS Employers told us about the work they had undertaken to support providers to improve nurse retention, indicating three areas of focus:

- Increasing support for newly qualified nurses
- Return to practice schemes for nurses who have retired but wish to return to nursing
- Career development for nurses.<sup>69</sup>

40. The first point, increasing support for newly qualified nurses, is a clear area for further action. The Capital Nurse scheme told us that nearly 20% of newly qualified nurses in their area leave within their first year and about their plans to tackle this.<sup>70</sup>

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62 Q30  
 63 Q35  
 64 Annex 1  
 65 Q326  
 66 Q199  
 67 Annex 1  
 68 Q48  
 69 Q34  
 70 Q156

41. Nurses at our focus groups told us that staff shortages mean that newly qualified staff face a hugely challenging working environment and that established staff simply do not have time to support them adequately.<sup>71</sup>

42. On career development, we heard that often nurses want to broaden their experience by transferring between departments, providers and specialities. However current employment practices do not always make it easy to do so. We heard about bureaucratic barriers to nurses applying for internal vacancies within their own organisation.<sup>72</sup> We also heard about other barriers needlessly preventing the recognition of skills when nurses move organisations.<sup>73</sup> This not only gets in the way of flexible career paths but denies patients and professional colleagues the benefit of nurses' expertise. We heard that nurses have to specialise very early in their training, and opportunities to switch to a different speciality later in their careers are limited.<sup>74</sup> The Capital Nurse scheme in London is attempting to overcome these problems and offer early career stage nurses increased choice and flexibility over their career paths.<sup>75</sup>

## Conclusions and recommendations

43. We welcome the focus to date on the supply of new nurses but these will take time to deliver. There therefore needs to be a greater focus on retention, driven by an explicit commitment to making the nursing workforce feel valued including increasing the opportunities for professional development.

44. Our evidence suggests a clear need for national action to:

- improve nurses' access to continuing professional development; and
- improve nurses' working conditions.

**45. We note the work that is already under way by NHS Employers and NHS Improvement to support trusts with retention, and we recommend that this work should continue, with a specific focus on initiatives that will increase the opportunities for nurses to access high quality continuing professional development, flexible career pathways and flexible working. NHS England, NHS Employers and HEE should facilitate transfers and training for nurses who wish to move between departments, organisations and sectors and remove unnecessary bureaucratic barriers which prevent recognition of their skills**

**46. Health Education England must reverse cuts to nurses' continuing professional development budgets. Funding allocated to trusts should be specifically ringfenced for CPD for nurses, and specific funding should be made available to support CPD for nurses working in the community.<sup>76</sup> We also recognise the need for Health Education England to be able to support training in areas where the NHS has skills shortages. We heard a clear message that access to continuing professional development plays an important role in retention. It will also need to reflect skill shortages and patient**

71 Annex 1, Annex 2

72 Q34

73 Q162

74 Annex 2

75 Capital Nurse ([NWO0090](#))

76 The term 'community' includes community nurses, district nurses, primary care nurses, and nurses working in social care settings.

needs. This change should be clearly communicated to nurses both by national bodies and by employers, and a clear audit trail should be available to ensure that funding reaches its intended destination. We will review progress on this recommendation in one year, and will expect HEE to be able to demonstrate clear action on each point.

47. The Chief Nursing Officer should take a lead in setting out how to ensure that nurses are working in safe and acceptable working conditions. Nurses must be able to hand over patients to colleagues safely, without routinely staying late; nurses must be able to take breaks; and nurses must have access to facilities to make food and drink near their place of work.

48. There needs to be a greater focus on staff wellbeing in all areas. This work should be driven forward as a national policy priority, and nurses of all grades and from all settings should contribute to it.

49. As a first step, we recommend that the Chief Nursing Officer should write to all Directors of Nursing, including in social care providers, asking them to confirm whether their nurses are able to complete handovers without routinely staying late, and whether they have time to take their breaks.

50. The Chief Nursing Officer should establish a nursing wellbeing reference group, with membership of nurses from all grades, career stages and settings, which should design and oversee a programme of work to monitor and help to advise on improving nurses' working conditions.

51. Underpinning all this is the pressing need to expand the nursing workforce at scale and pace. Without that action, many nurses will continue to experience unacceptable pressure, and will continue to leave the nursing profession.



## 2 New nurses

### Introduction

52. The NHS, social care and other healthcare services rely on a continuous flow of newly qualified nurses, with the right knowledge, skills, qualities and values to deliver high-quality care. The education of aspiring nurses in England has radically changed in a short space of time. The student funding reforms in 2015 shifted the funding of undergraduate nursing courses in England away from a centrally commissioned system. Universities no longer have a cap on the number of places they can offer but equally, nurses no longer have access to bursaries and have instead to take out student loans. There are many moving parts when it comes to assessing the impact of new routes into nursing. These include the Nursing Associate and apprenticeship routes onward to degree nursing, and the Nurse First programme, which all provide new routes into the profession. Return to practice schemes also offer a way for nurses who have left the profession to retrain.

53. We welcome the introduction of new and diverse routes into nursing. However, we heard the clear message from our witnesses that these new routes should not be seen as the solution to the current workforce shortfall: undergraduate nursing remains the main way of training nurses.<sup>77</sup> Nursing Associate and Apprenticeship routes take longer than standard undergraduate training, and capacity to deliver nurse training through these routes in sufficient numbers does not yet exist. Only 30 people began training as a nurse through Nursing Apprenticeship schemes this year.<sup>78</sup> We heard that they offered an attractive route for mature students and those with dependents.<sup>79</sup> 2,000 have now started training as Nursing Associates, with this number projected to grow to 7,500 per year by 2019, but not all of those who train as Nursing Associates will want to carry on to degree level nursing. HEE projections suggest that from 2021, around 2,400 new nurses might qualify per year as degree level nurses having come first through the Nursing Associate route, but this only a small proportion of the total—22,000—expected to graduate each year through undergraduate courses.<sup>80</sup>

54. Fast track schemes and return to practice schemes have the potential to train (or retrain) nurses more quickly, but again the numbers are currently low – 40 for Nurse First, and 1,000 per year for return to practice.<sup>81 82</sup>

55. It is therefore essential that there is clarity that three-year undergraduate courses currently provide the majority of entrants to the nursing register, providing the fastest large-scale route for training nurses.

77 Q56

78 RCN ([NWO0113](#)) para 3:10

79 Q211

80 Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), December 2017; p9 - HEE estimates that by 2027, 17,000 will have become nurses, having first trained as Nursing Associates. Assuming the first qualify as nurses in 2021, this gives approximately 2,400 each year between 2021 and 2027.

81 Department of Health ([NWO0089](#)) para 46

82 Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), page 49

## Student funding reforms

56. Funding and financial support for student nurses starting undergraduate courses from August 2017 is now provided through the Student Loans Company, rather than the NHS bursary scheme. Under the NHS bursary scheme the number of nurse training places was capped, and the number of applications exceeded the number of places available by two to one.<sup>83</sup> Many nurses also complained that the bursaries did not meet the cost of living and that there was no access to student loans for top ups.<sup>84</sup>

57. Applications to undergraduate nursing courses in England in 2017/18 dropped by 23% compared to 2016/17. However, Scotland, Wales and Northern Ireland also experienced a drop in applications, despite retaining the bursary, but these are smaller than the falls in England - the number of applicants is down by 10% in Wales compared with 2016, with reductions of 6% seen in Northern Ireland and 2% in Scotland.<sup>85</sup> Even with a 23% reduction in applications, demand for places in 2017/18 still exceeded the number of places available by two to one.

58. UCAS data published in December shows a 3% fall in the number of placed acceptances, with 585 fewer students starting nursing degrees this September compared with last year. However HEE argue in their Workforce Strategy that their own analysis, based on information collected from universities, suggests that the number of student nurses starting in 2017 will at least be equal to the student numbers in 2016.<sup>86</sup>

59. It is too early to draw firm conclusions about the impact of student funding reforms on the supply of nurses. While applications have dropped, the number of places available has not yet expanded as anticipated. One reason for that is that all nursing degrees involve a clinical placement, and there have been delays in expanding clinical placement capacity. The Government has committed to funding an extra 5,000 clinical placements per year from 2018–19, which will increase nurse training places by 25%.<sup>87</sup> The delay in planning for new placements, however, risks increasing the pressure on numbers of newly qualified nurses at a critical time.

## Adverse impacts on specific groups

60. Our evidence raised concerns that mature students wishing to pursue the university degree route may be disproportionately dissuaded or diverted by the funding changes, and evidence to date seems to support this concern. We were told by Health Education England that:

Although we do not have the robust data yet, it certainly seems that the average age of the nursing students entering university this year is significantly lower than it has been in previous years. That is undoubtedly because a number of the mature entrant students have not chosen to apply to do a degree that is funded through the student loan route. We need to

83 Health Foundation, [Rising pressure: the NHS workforce challenge](#), October 2017

84 Department of Health, [Reforming healthcare education funding: creating a sustainable future workforce](#), May 2016

85 Health Foundation, [Rising pressure: the NHS workforce challenge](#), October 2017, page 5

86 Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), December 2017; p109

87 PQ HL1997 on [Nurses: training](#) 24 October 2017

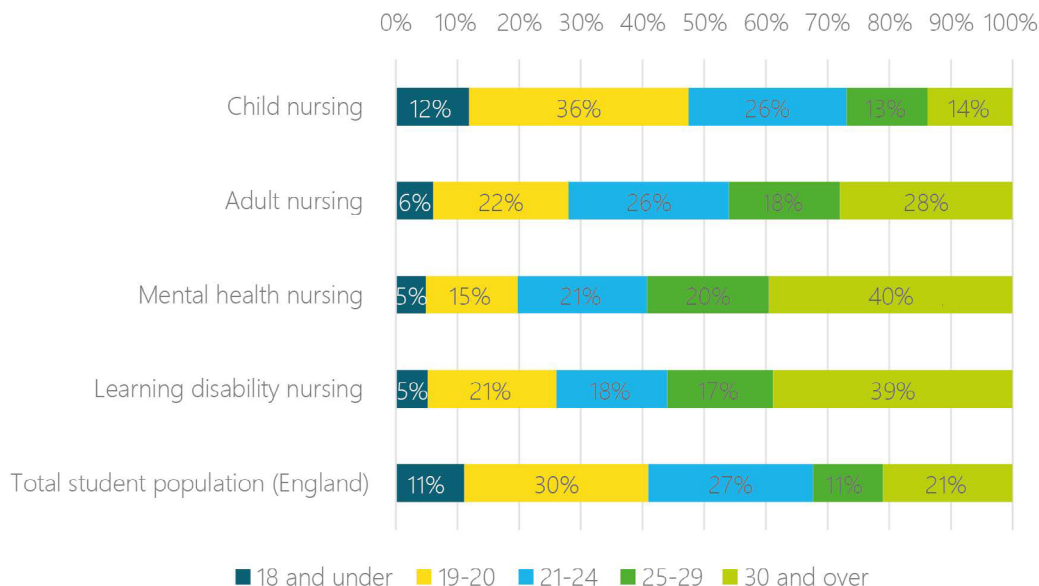
watch that; we need to see what happens; but part of the solution we are pursuing to this is that we want to keep the richness that we have within the registered nursing workforce.<sup>88</sup>

61. Figures just published by UCAS confirm a drop in older nursing students:

the number of acceptances for older age groups fell in 2017. This year, 4,575 applicants aged 21 to 25 were accepted, a fall of 680 (-13 per cent) compared to 2016, and 8,450 applicants aged 26 and over were accepted, a fall of 545 (-6.0 per cent).<sup>89</sup>

62. This is of great concern, given that a significant proportion of trainee nurses are over the age of 25. Of particular concern is the fact that mature students make up an even larger proportion of students in the shortage areas of mental health nursing and learning disability nursing.<sup>90</sup>

Percentage of enrolled students on NMC regulated pre-registration nursing programmes in England by age (2015/16)



Data source: HESA Student Record (2015-16) Copyright Higher Education Statistics Agency Limited

63. Mature students are more likely to remain in the profession<sup>91</sup>—a significant benefit given the high level of attrition from nursing courses and the loss of newly qualified nurses in the first five years after graduation.<sup>92 93</sup> Attrition rates are discussed in more detail below.

64. Another area of concern is the impact on courses for specialties which already have higher vacancy rates, particularly mental health and learning disability courses. We have heard that some universities providing undergraduate courses in mental health and learning disability nursing have struggled to recruit sufficient students this year, threatening the financial viability of these courses. Sheffield Hallam University managed

88 Q211

89 UCAS [End of Cycle Report 2017](#), p16

90 Council of Deans for Health ([NWO0010](#)) para 8

91 Shelford Group ([NWO0114](#)) para 30

92 Health Foundation, [Rising pressure: the NHS workforce challenge](#), October 2017

93 Q119

to recruit just 70% of its target intake, while London South Bank University decided not to run its learning disability programme this year due to a shortage of applicants.<sup>94</sup> The impact of the student funding reforms on smaller courses was raised in response to the Government's consultation on these reforms. In its response the Department of Health committed to closely monitoring and intervening to prevent "damaging falls" in student demand or course supply.<sup>95</sup>

## Attrition

65. Historically a large percentage of student nurses have failed to complete their training, with the rate of attrition varying widely between universities. Health Education England's Reducing Pre-Registration Attrition and Improving Retention (RePAIR) project aimed to reduce unnecessary attrition and identify areas of best practice in retaining student nurses. Initial results from RePAIR show that 30% of students who were due to complete in either 2015/16 or 2016/17 failed to complete within the standard time period.<sup>96</sup>

## Apprenticeship Levy

66. The introduction of the Apprenticeship Levy, and the subsequent creation of apprenticeships standards for graduate nursing, has been welcomed as an alternative new route into nursing which is employer-led, enabling NHS and social care services to grow their own workforce. However, we heard that there are financial difficulties for providers in implementing it. Danny Mortimer, Chief Executive of NHS Employers, emphasised this point, saying the Apprenticeship Levy

... carries extra cost, which we do not believe has been properly factored in. We think the cost is probably something in the region of £125,000 to £155,000 over the four years of a nursing apprenticeship, and the levy will not capture all that cost. Of course, the levy is money that is being taken off us anyway that we have to claim back. So, while we welcome the route, the financing of it is tricky.<sup>97</sup>

67. Professor Ian Cumming from HEE signalled the possibility of introducing co-ordination of apprenticeship levy funding on a larger footprint, potentially an STP, as way of reducing the burden on individual services, while retaining an employer-led approach.<sup>98</sup>

## Fast-track routes and return to practice schemes

68. A fast track scheme for graduates to train as nurses in two years, Nurse First, has been introduced by NHS England and Health Education England. The first cohort is specifically targeted at mental health and learning disability nursing to address shortages

94 Sheffield Hallam University ([NWO0117](#)) p2; Q50

95 Department of Health, [Reforming healthcare education funding: creating a sustainable future workforce](#), July 2016

96 It is important to note that this includes any student who took longer to complete courses - for example due to educational or personal reasons. Department of Health ([NWO0121](#)) para 8

97 Q50

98 Q336

in these areas.. However, there are currently only 40 students on this programme. We were told that these courses were popular and oversubscribed, and that expanding this route into nursing could prove fruitful.<sup>99</sup>

69. The national return-to-practice scheme for nurses has been run by HEE since 2014 and provides experienced nurses with training and a route back into the NHS. To date over 2,400 have completed and entered NHS employment. This programme is being expanded with a target of 1,000 each year.<sup>100</sup>

## Conclusions and recommendations

70. We welcome the introduction of new and diverse routes into nursing. However, these new routes in the main take longer than the standard undergraduate nursing degree, and are currently small-scale. Three-year undergraduate courses are the predominant route of entry to the nursing register, providing the fastest large-scale route for training nurses.

71. It is essential that the Government monitors very closely the impact of the changes to the funding for undergraduate nursing over the coming year and responds swiftly if there are signs that it will further increase the shortfall in the nursing workforce.

72. This year there has been a significant reduction in applications to nursing degrees, and a small reduction to the numbers taking up nursing degrees. There has also been delay to the expansion in nursing places that was heralded as one of the advantages of moving away from bursaries. In our view, it is not enough simply to increase the intake of new nurses. These reforms will only be successful if they protect, and in time enhance, the diversity and sustainability of the nursing workforce. There are also early indications of reductions in the numbers of mature students, which is particularly worrying as they are more likely to stay in the longer term in nursing and in the area in which they trained. People who enter nursing later in life also enrich this workforce by bringing a broader life experience. It will be especially important to maintain an attractive entry route for mature students in community, mental health, and learning disability settings, where there are already significant shortages and where mature students form a large proportion of newly qualified nurses. We are concerned by the difficulties universities have experienced in attracting students onto mental health and learning disability courses since the withdrawal of nursing bursaries.

**73. While it is too early to draw firm conclusions about the impact of the withdrawal of bursaries and the introduction of student loans and apprenticeships, there are early warning signs of emerging problems. In its response to this report, the Government should set out a) how it is monitoring this situation, and b) what specific actions it will take i) if applications, especially from mature students and to courses in shortage specialities, continue to fall, and ii) if courses are undersubscribed.**

**74. We were particularly concerned to hear that 30% of nursing undergraduates do not complete their course, and we would like further assurance from HEE that attrition rates have been taken into account in future workforce projections. There is stark variation in the attrition rate for nursing degree courses. This must be closely**

99 Q60

100 Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), December 2017; p48

**monitored, and HEE and the Government must hold universities and NHS provider organisations to account for investigating and addressing the causes. In response to this report we want to see action to reduce variations in attrition rates between institutions and will follow this up in a year to ensure progress has been made in bringing low performers up to the level of the best.**

### 3 Nursing associates

#### A new role and opportunity

75. The new role of nursing associate was first announced in December 2015.<sup>101</sup> This will provide a bridge between healthcare assistants and registered nurses. Nursing Associates will provide direct patient care, including some tasks usually performed by nurses. They will complete a two-year training programme, most of which will be whilst working as a full member of a healthcare team, rather than on a supernumerary basis, as student nurses are. For this reason, trainee nursing associates receive a salary from their employer but they will also spend some time in different educational settings. After completing their two-year training, they will become professionals registered with the Nursing and Midwifery Council (NMC).

76. To date, Trainee Nursing Associates have been recruited from existing NHS staff—mostly Healthcare Assistants. After TNAs qualify, it is intended that they will have a choice of either practicing as Nursing Associates, or continuing their training for a further two years to progress to degree nursing. The full details of how this second, extended offer of training will work are not yet clear nor where a rollout of these training placements will be offered.

77. The first two cohorts—2,000 trainee nursing associates in total - have now begun their training, A further 5,000 will begin training next year, and a further 7,500 will begin in 2019.<sup>102</sup>

#### A role in its own right

78. Nursing Associates are intended to supplement nurses rather than replace them, but may ease pressure by freeing up registered nurses' time for tasks that require their degree-level skills. Witnesses to our inquiry expressed serious concern that, particularly given the current shortage of nurses, NAs might be used to substitute for registered nurses. Those giving evidence to us, including perhaps most importantly TNAs themselves, were clear that the Nursing Associate role must be seen as a role in its own right. The Council of Deans for Health, the organisation that represents faculties which train healthcare professionals, told us unequivocally

We see them as a member of the workforce in their own right. Some of them may choose—I emphasise the words “may choose”—to use that qualification to move into becoming a registered nurse and do further training. It is a long way to do it, but some of them may choose to do that.<sup>103</sup>

79. Our evidence was clear that NAs will be welcome additions to the workforce, providing far more than ‘more hands on deck’, but more skilled hands.<sup>104</sup> However, it is clear that they are only part of the solution to the current nursing shortage. It will take

101 Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), December 2017; p39

102 Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), December 2017; p39

103 Q100

104 See for example, Q170; Annex 2.



a minimum of four years for a TNA to progress into the registered nursing workforce. Even setting aside the lead-in time, the numbers expected to go through this route are small compared to conventional undergraduate nursing. The projections in HEE's Draft Workforce Strategy suggest that ten years from now 17,000 NAs may have progressed to become registered nurses—so around 2,400 per year from 2021, which is the earliest time the first NAs could enter the degree nursing workforce.<sup>105</sup> This compares to around 22,000 per year through undergraduate nursing courses.<sup>106</sup>

## Emerging issues from the pilot

80. We met a group of over 40 trainee nursing associates and their supervisors at a visit organised by Health Education England and hosted by the Royal London Hospital.

81. The group we met were on the whole extremely positive about the training scheme, and the opportunity it was giving them to enhance their skills, to get professional recognition through entering a new registered profession, and in the long term, if they wished, to progress their careers still further to become nurses.<sup>107</sup>

82. TNAs described some problems relating to the quality of and consistent access to teaching, and the organisation of placements. We were told that as this was a pilot scheme introduced very quickly, it was being carefully monitored by HEE and emerging problems were being tackled. Trainees were extremely positive about the opportunities to work and learn in other specialties, particularly mental health and social care, which we find very encouraging. The TNAs we met were hugely positive about the new role as an opportunity for continuing professional development.<sup>108</sup>

83. Those managing the scheme told us that although they were fully supportive and engaged in it, it is not cost neutral for providers, as TNAs leave their workplace for two days a week for training purposes, and there is no funding available to backfill their posts for the two days a week they are training in other settings.<sup>109</sup>

## A need for greater clarity

84. The clear message we received from TNAs, also reinforced by other written and oral evidence received, was the need for greater clarity about the NA role.

85. TNAs told us that there is currently a lack of clarity about how their role within the team is described and understood, particularly in relation to other support roles, such as healthcare assistants, and in relation to other training roles, such as student nurses. We heard that there was an ongoing lack of clarity about this, even sometimes at a senior organisational level.<sup>110</sup>

105 Health Education England, [Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027](#), December 2017; p9

106 Q191

107 Annex 2

108 Annex 2

109 Annex 2

110 Annex 2



86. As TNAs near completion of their training, managers need to know the skills NAs will have on qualification, in order for them to be taken into account during workforce planning.<sup>111</sup>

87. Finally, NAs need and want to develop a clear professional identity that can be communicated clearly to patients and the wider public. They should not be viewed or referred to as ‘*nurses on the cheap*’, and this message must be clearly articulated at national as well as local level. This is however more likely to happen if managers use NAs as a substitute for nursing posts. Where nursing posts cannot be filled, it will be essential to keep those posts open rather than to fill them with NAs and then withdraw the advertisement for the post. NAs also need a uniform or other identification that celebrates their achievement, and makes clear to patients and the public that this is a new role in healthcare.<sup>112</sup>

## Conclusion and recommendation

88. We are supportive of this new route for HCAs to train as NAs and on into degree level nursing. Too many dynamic, motivated and committed members of the workforce were being lost because of the lack of career opportunities for HCAs. NAs will be a new regulated profession, with further opportunities to break through the glass ceiling into nursing. If they are properly deployed, NAs have the potential to greatly enhance patient care. However, there is an urgent need for greater clarity as this important role is developed and introduced.

89. **Nursing associates need and deserve a clear professional identity of their own and we recommend that development and communication about this role should be led nationally. Clarity about the NA role, and the scope of their practice, is also essential for patient safety. There must be a clear understanding that NAs are registered professionals in their own right, supplementing rather than substituting for nurses. Alongside the professional standards being developed by the NMC against which NAs will be regulated, we recommend that a ‘plain English’ guide to the new role should be developed, published and communicated at both a national and a local level. This guide should include examples of tasks that NAs will, and will not, be expected to undertake, but will need also to reflect the scope of their practice across a range of healthcare settings.**

90. Nursing associates have the potential to greatly enhance patient care, and also to add diversity to the nursing workforce, alongside apprenticeships allowing people to become nurses for whom the traditional degree route might not be an option. However, it is clear that if and when TNAs do go on to become registered nurses, their numbers will only ever be a very small proportion of the total nurses in training. It is therefore essential that the nursing associate role is not viewed or portrayed as the only solution to the current shortfall in the nursing workforce.

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111 Annex 2

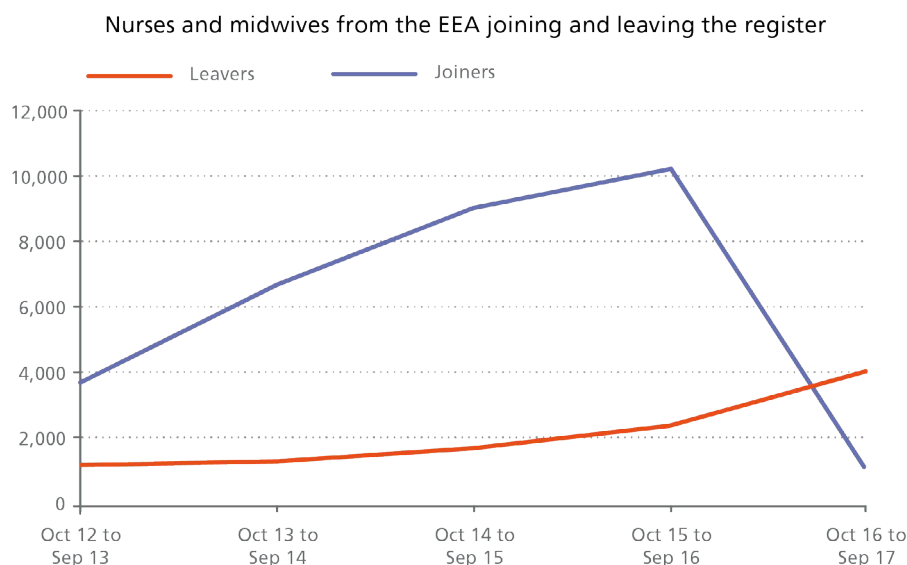
112 Annex 2

## 4 Nurses from overseas

91. Nurses from outside the UK have always played a vital and highly valued role in delivering care to patients in both the acute sector and in the community.

92. Only relatively small numbers of nurses from outside the EU have been joining the UK register in recent years - 2,403 joined between March 2016 - March 2017. This represents a very significant decline compared with much larger scale overseas recruitment in the early 2000s, when between 10,000 and 15,000 were joining per year.<sup>113</sup> This was followed by an increase in the number of nurses from the EU coming to work in the UK, which peaked at over 9,000 in 2015–16.<sup>114</sup>

93. While the number of joiners and leavers from outside the EU has remained at a relatively stable low level in recent years, the upward trend in EEA nurses joining the UK register has been reversed in the past year—with only 1,107 joining the register between October 2016—October 2017, and 4067 leaving, up from 2,435 the previous year.<sup>115</sup> There has been an 89% drop in the number of people from the EEA joining the register between October 2016 and September 2017. The President of the RCN told us that if this continued, “It will be quite devastating for our workforce.”<sup>116</sup> The Minister told the Committee that data showed a smaller reduction in the number of EU nurses working in the NHS.<sup>117</sup> Data recently published by NHS Digital show a net reduction of 1,212 EU nurses working in the NHS as at September 2017<sup>118</sup>



Source: The NMC register, 30 September 2017 (pp. 6-8)

113 Nursing and Midwifery Council [The NMC register 2012/13 - 2016/17](#), July 2017 p4; Health Foundation, [Rising pressure: the NHS workforce challenge](#), October 2017; p29

114 Nursing and Midwifery Council, [The NMC register 2012/13 - 2016/17](#), July 2017- p3

115 Nursing and Midwifery Council, [The NMC register, 30 September 2017](#), November 2017

116 Q66

117 Q315. This differs from the NMC figure, as the NMC register includes all nurses and midwives registered to practice throughout the UK.

118 Source – NHS leavers/ joiners data for the year ending Sep 2017, [NHS Workforce Statistics, September 2017](#), [HCHS Staff in NHS Trusts and CCGs](#)

Time-series of recorded staff numbers by nationality gives a lower reduction of 991. This discrepancy likely to be due to reduction in the number of staff whose nationality is recorded as ‘unknown’, owing to turnover, and also to better data collection.

94. Whilst some of this decline may be as a result of the EU referendum result, there are other variables to consider such as recovering economies elsewhere in the EU27, the decline in value of the Pound and the impact of the introduction of language testing.

## Language testing

95. Evidence to our inquiry highlighted language testing as a significant barrier to nurses coming to work in the UK.<sup>119</sup> Language tests are specified as part of the NMC's registration process. Overseas nurses from outside the EU have had to complete language tests since 2001. The standard required in the International English Language Testing System (IELTS) was increased in 2007. Language testing was then introduced for EU nurses in July 2016—the NMC argue that these changes were essential to ensure nurses coming from the EU are able to communicate effectively with patients, which is fundamental to patient safety.<sup>120</sup>

96. The NMC introduced changes to its language tests in November 2017, introducing different ways for applicants from overseas to meet the English Language requirements. Some of our written evidence expressed the view that these changes were insufficient.<sup>121</sup> The view of the Chief Nursing Officer was that it was too early to assess the impact of the changes, but that the situation needed to be monitored closely.<sup>122</sup> Initial data suggest an increased number of people applying for the new tests, but it is too early to draw firm conclusions.<sup>123</sup>

## Reassurance for EU nurses

97. The timing of the introduction of language tests for EU nurses, almost immediately after the UK voted to leave the EU, means that it is very difficult to separate the effect of the 'Leave' vote and the effect of the new language tests on the reducing number of EU nurses applying to practice in the UK.

98. However, the introduction of new language testing does not explain the increasing number of EU nurses now leaving the UK, as the test is only for new entrants, and it is likely that at least some of the increase in EU nurses leaving the UK is the result of uncertainty surrounding the UK's future relationship with the EU.

99. EU nurses at our focus groups told us that they and colleagues needed reassurance, as many of their colleagues had returned to their home countries because of uncertainty over their future status.<sup>124</sup> Although communications have been made on this issue, further assurance is needed to retain EU staff in the NHS. Questioned about this situation by the Chair of this Committee at Prime Minister's Questions on 13 December 2017, the Prime Minister provided the following response:

I am very happy to [thank] all who work in our NHS and social care sector, including those from across the European Union. They do incredible work, and it is absolutely right that we recognise the contribution that EU nationals

119 See for example Overseas nurses currently working in the health care sector in the UK ([NWO0037](#)); BUPA UK ([NWO0037](#)); NHS Employers ([NWO0084](#)).

120 NMC ([NWO0073](#)) para 32

121 See, for example, NHS Professionals ([NWO0124](#))

122 Q269

123 Q271

124 Annex 1

make in this sector but also across our economy and our society. That is why we want people to be able to stay and we want families to be able to stay together. I am very pleased that the arrangements that were published in the joint progress report between the United Kingdom and the European Union last Friday show very clearly, on citizens' rights, that where people have made the life choice to be here in the United Kingdom, we will support them and enable them to carry on living their lives as before.<sup>125</sup>

## A national recruitment drive

100. We have been told that increasing the scale of recruitment of overseas nurses is now essential for the UK, and that this needs to be done nationally, rather than by each local organisation making its own attempts to recruit internationally. NHS Employers argued that

The reality is that in the NHS, in social care, and in other parts of healthcare we are very dependent on an international workforce to close the gap that [has been] described. We need to see not just a response to Brexit, but a response in terms of non-EEA recruitment that makes it as easy as possible, whether it is in social care, the NHS or other settings, to bring in the staff we need from elsewhere in the world in a way that is ethical.<sup>126</sup>

Clare Johnson, Project Director for Capital Nurse, added:

It is highly likely that we will be reliant, certainly in London, on international recruitment for some foreseeable time to come ... I think we need a single, centralised approach to that. International recruitment that is really beyond any individual trust.<sup>127</sup>

101. We were told by the Chief Nursing Officer that national-level recruitment of overseas nurses had been considered a few years ago, but not pursued.<sup>128</sup> Health Education England told us that it is introducing a scheme to bring nurses to the UK on an 'earn, learn and return' basis, beginning with an initial cohort of 500 nurses who have come to live and work in Harrogate. The plan is for this to increase in scale to 5,500 nurses.<sup>129</sup>

102. We heard that, in common with all professionals, overseas nurses want access to CPD and clear career structures, both of which are currently lacking.<sup>130</sup> Nurses at our focus group commented that when new colleagues arrive from the EU and further afield, it is very difficult to give them proper support when they arrive. It can also be difficult to find accommodation, and transition and administrative arrangements need to be smoother.<sup>131</sup>

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125 HC Deb, 13 December 2017, [col 395](#) [Commons Chamber]

126 Q16

127 Q177

128 Q269

129 Q222

130 Q107

131 Annex 1

103. Nursing is currently on the Shortage Occupation List,<sup>132</sup> but that is a time-limited position. Our witnesses from provider organisations were clear that a long-term solution needs to be put into place that enables the continued recruitment of the nurses needed from overseas on an ongoing basis:

To repeat a point that we touched on about nursing being on the shortage occupation list at the moment, which helps us recruit nurses from outside the EU, it is a time-limited placement that is due to end in two years' time. We cannot see that that makes any sense at all. Whatever the migration policy is to be in the coming years, and post Brexit in particular, we need that special status for nurses to remain for some significant period of time.<sup>133</sup>

104. Lord Willis, a member of the Lords' Committee on the Long Term Sustainability of the NHS and Chair of the Shape of Caring review, pointed out to us that the UK is not the only nation needing to recruit extra nurses internationally, and is likely to face continued competition within the international employment market.<sup>134</sup> The Government needs to find an approach to international recruitment which is both effective and ethical.

## Conclusion and recommendation

105. Given the scale of the shortages in the nursing workforce, and the length of time it takes to train new nurses, the UK will continue to depend on nurses from overseas for a considerable time. It is essential that overseas recruitment is undertaken responsibly and ethically, and nurses from overseas need to be welcomed and recognised for their skills and valued contribution.

**106. Whilst welcoming the proposal for a central recruitment programme for overseas nurses, we have not seen evidence that it is being made to happen at the scale and pace needed. We recommend that Health Education England should work closely with NHS England, as well as working directly with health and social care providers, to develop an ethical overseas recruitment programme that will deliver the numbers of new overseas nurses needed in England in the short to medium term. This should be done as an immediate priority, and HEE's draft workforce strategy should be updated to include such a programme.**

**107. NHS England must closely monitor the situation regarding language testing to ensure it is at an appropriate level whilst not proving an unnecessary barrier to recruiting trained international nurses. We recommend that in response to this report NHS England provide us with a report setting out how they are monitoring the situation, what the data show following the NMC's changes, and what action they are taking as a consequence. We will then expect an update on that report on 1st November 2018.**

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132 The shortage occupation list is an official list of occupations for which there are not enough resident workers to fill vacancies. The [Migration Advisory Committee \(MAC\)](#) regularly reviews the list and calls for evidence of which occupations should be included or removed. (Source - NHS Employers - further information can be found [here](#).)

133 Q83

134 Q103

**108. Further assurance is needed to retain EU nursing staff in England. We urge the Government to set out what further measures they will take to ensure the message—that they will be able to remain in the UK, irrespective of the final outcome of negotiations—is getting through.**

**109. It is in the national interest to ensure that migration policy ensures that the UK is able to recruit and retain the nursing workforce it needs. We ask the Department of Health to provide us with further evidence that it is taking this forward with urgency with other relevant Government Departments. We recommend that nursing remains on the shortage occupation list and that the current period is extended and kept under regular review.**

## 5 Workforce planning

110. Historically, workforce planning has suffered from short termism and has lacked a coherent, long term strategic view. HEE published its Draft Workforce Strategy on 13 December 2017. We are pleased that it has been published as a draft strategy for consultation, and we urge the Government to ensure that the final version takes account of our recommendations.

### Future projections—affordability or need?

111. In its report on NHS workforce planning, published nearly two years ago, the National Audit Office reported that workforce planning had been based on unrealistic projections driven by affordability rather than need.<sup>135</sup> Future projections of need for nursing staff should be based on demographic and other demand factors rather than affordability. However, evidence to this inquiry did not express confidence that this was the case.<sup>136</sup> Although the Draft Workforce Strategy does contain future high-level projections for the coming years, the methodology behind these projections is not clear.

### Data

112. The NAO also recommended that better workforce data needed to be gathered to inform planning.<sup>137</sup> The evidence from this inquiry indicates that the data problems described by the NAO have not been rectified. In particular, the RCN pointed out to us that there were little data available about the nursing workforce in the independent or third sectors.<sup>138</sup> NHS Providers described the need to get an agreed and consistent data set:

While it is widely accepted that there is a nursing shortage, there is no agreed measure of its scale. Consistent data for nursing vacancy, retention and leaver rates at a local and national level are still widely unavailable. In addition, there is a lack of insight into regional variation and differences between fields of nursing.<sup>139</sup>

113. While the draft Workforce Strategy commits to efforts to improve this situation, it is disappointing that it has taken two years for HEE to begin to act on the NAO's recommendation.

### Sustainability and Transformation Partnerships

114. Provider organisations and their local health economies play an important role in workforce planning, providing local projections of anticipated need to HEE. Sustainability

135 National Audit Office, [Managing the supply of NHS clinical staff in England](#), pp 9–10 paras 13 - 14

136 Q18; Nursing Times ([NWO0058](#)) para 4.1.10

137 National Audit Office, [Managing the supply of NHS clinical staff in England](#) p13

138 Q20

139 NHS Providers ([NWO0076](#)) p1



and Transformation Partnerships (STPs)<sup>140</sup> provide a mechanism to enable services to collectively address workforce shortages, removing competitive behaviours between services for a limited pool of staff, and enabling areas to develop and grow their own local workforce. This place-based focus will be critical, given the shortage of community nursing staff and the impact that this is likely to have on the ability to reduce delayed transfers of care, and to deliver care closer to home.

## Conclusion and recommendations

**115. We recommend the development of a nationally agreed dataset to enable a consistent approach to workforce planning and an agreed figure for the nursing shortfall. This dataset should include figures on how many nurses have taken up advanced practitioner roles. The Department of Health and its arm's length bodies must ensure there is robust, timely and publicly available data at a national, regional and trust level on the scale of the nursing shortage.**

**116. Future projections of need should be based on demographic and other demand factors rather than just affordability. They also need to include proper consideration of the interrelated nature of the social care and other non-NHS nursing and wider healthcare workforce. HEE should publish detailed projections for nursing staff for the coming years—both numbers entering the workforce from different routes and the anticipated need for staff—and must clearly set out the basis on which its future projections of need for nursing staff are made. These projections must include nurses working in and outside the NHS.**

**117. The Draft Workforce Strategy describes plans to improve workforce data. This is long overdue, and we will ask the Department and HEE to provide us with an update on these plans in six months' time.**

**118. Sustainability and Transformation Partnership and Accountable Care System workforce plans need full scrutiny from HEE. This scrutiny should be carried out in a timely and transparent manner and take account of, and look to redress, shortages in community nursing. In response to this report, Health Education England must set out its planned timescales for undertaking this scrutiny, and we will expect it to supply us with a report of its scrutiny of STP workforce plans when they have been completed.**

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<sup>140</sup> STP stands for sustainability and transformation partnership. These are 44 areas covering all of England, where local NHS organisations and councils have drawn up proposals to improve health and care in the areas they serve. STP can also stand for 'sustainability and transformation plan', plans drawn up in each of these areas setting out practical ways to improve NHS services and population health in every part of England. They aim to help meet a 'triple challenge' set out in the NHS Five Year Forward View – better health, transformed quality of care delivery, and sustainable finances. Source - NHS England <https://www.england.nhs.uk/systemchange/faqs/>



## Conclusions and recommendations

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### Retention—keeping the current workforce

1. We note the work that is already under way by NHS Employers and NHS Improvement to support trusts with retention, and we recommend that this work should continue, with a specific focus on initiatives that will increase the opportunities for nurses to access high quality continuing professional development, flexible career pathways and flexible working. NHS England, NHS Employers and HEE should facilitate transfers and training for nurses who wish to move between departments, organisations and sectors and remove unnecessary bureaucratic barriers which prevent recognition of their skills (Paragraph 45)
2. Health Education England must reverse cuts to nurses' continuing professional development budgets. Funding allocated to trusts should be specifically ringfenced for CPD for nurses, and specific funding should be made available to support CPD for nurses working in the community. We also recognise the need for Health Education England to be able to support training in areas where the NHS has skills shortages. We heard a clear message that access to continuing professional development plays an important role in retention. It will also need to reflect skill shortages and patient needs. This change should be clearly communicated to nurses both by national bodies and by employers, and a clear audit trail should be available to ensure that funding reaches its intended destination. We will review progress on this recommendation in one year, and will expect HEE to be able to demonstrate clear action on each point. (Paragraph 46)
3. The Chief Nursing Officer should take a lead in setting out how to ensure that nurses are working in safe and acceptable working conditions. Nurses must be able to hand over patients to colleagues safely, without routinely staying late; nurses must be able to take breaks; and nurses must have access to facilities to make food and drink near their place of work. (Paragraph 47)
4. There needs to be a greater focus on staff wellbeing in all areas. This work should be driven forward as a national policy priority, and nurses of all grades and from all settings should contribute to it. (Paragraph 48)
5. As a first step, we recommend that the Chief Nursing Officer should write to all Directors of Nursing, including in social care providers, asking them to confirm whether their nurses are able to complete handovers without routinely staying late, and whether they have time to take their breaks. (Paragraph 49)
6. The Chief Nursing Officer should establish a nursing wellbeing reference group, with membership of nurses from all grades, career stages and settings, which should design and oversee a programme of work to monitor and help to advise on improving nurses' working conditions. (Paragraph 50)

### New nurses

7. While it is too early to draw firm conclusions about the impact of the withdrawal of bursaries and the introduction of student loans and apprenticeships, there are early warning signs of emerging problems. In its response to this report, the Government should set out a) how it is monitoring this situation, and b) what specific actions it will take i) if applications, especially from mature students and to courses in shortage specialities, continue to fall, and ii) if courses are undersubscribed. (Paragraph 73)
8. We were particularly concerned to hear that 30% of nursing undergraduates do not complete their course, and we would like further assurance from HEE that attrition rates have been taken into account in future workforce projections. There is stark variation in the attrition rate for nursing degree courses. This must be closely monitored, and HEE and the Government must hold universities and NHS provider organisations to account for investigating and addressing the causes. In response to this report we want to see action to reduce variations in attrition rates between institutions and will follow this up in a year to ensure progress has been made in bringing low performers up to the level of the best. (Paragraph 74)

### Nursing associates

9. Nursing associates need and deserve a clear professional identity of their own and we recommend that development and communication about this role should be led nationally. Clarity about the NA role, and the scope of their practice, is also essential for patient safety. There must be a clear understanding that NAs are registered professionals in their own right, supplementing rather than substituting for nurses. Alongside the professional standards being developed by the NMC against which NAs will be regulated, we recommend that a 'plain English' guide to the new role should be developed, published and communicated at both a national and a local level. This guide should include examples of tasks that NAs will, and will not, be expected to undertake, but will need also to reflect the scope of their practice across a range of healthcare settings. (Paragraph 89)

### Nurses from overseas

10. Whilst welcoming the proposal for a central recruitment programme for overseas nurses, we have not seen evidence that it is being made to happen at the scale and pace needed. We recommend that Health Education England should work closely with NHS England, as well as working directly with health and social care providers, to develop an ethical overseas recruitment programme that will deliver the numbers of new overseas nurses needed in England in the short to medium term. This should be done as an immediate priority, and HEE's draft workforce strategy should be updated to include such a programme. (Paragraph 106)
11. NHS England must closely monitor the situation regarding language testing to ensure it is at an appropriate level whilst not proving an unnecessary barrier to recruiting trained international nurses. We recommend that in response to this report NHS England provide us with a report setting out how they are monitoring

the situation, what the data show following the NMC's changes, and what action they are taking as a consequence. We will then expect an update on that report on 1st November 2018. (Paragraph 107)

12. Further assurance is needed to retain EU nursing staff in England. We urge the Government to set out what further measures they will take to ensure the message—that they will be able to remain in the UK, irrespective of the final outcome of negotiations—is getting through. (Paragraph 108)
13. It is in the national interest to ensure that migration policy ensures that the UK is able to recruit and retain the nursing workforce it needs. We ask the Department of Health to provide us with further evidence that it is taking this forward with urgency with other relevant Government Departments. We recommend that nursing remains on the shortage occupation list and that the current period is extended and kept under regular review. (Paragraph 109)

### Workforce planning

14. We recommend the development of a nationally agreed dataset to enable a consistent approach to workforce planning and an agreed figure for the nursing shortfall. This dataset should include figures on how many nurses have taken up advanced practitioner roles. The Department of Health and its arm's length bodies must ensure there is robust, timely and publicly available data at a national, regional and trust level on the scale of the nursing shortage. (Paragraph 115)
15. Future projections of need should be based on demographic and other demand factors rather than just affordability. They also need to include proper consideration of the interrelated nature of the social care and other non-NHS nursing and wider healthcare workforce. HEE should publish detailed projections for nursing staff for the coming years—both numbers entering the workforce from different routes and the anticipated need for staff—and must clearly set out the basis on which its future projections of need for nursing staff are made. These projections must include nurses working in and outside the NHS. (Paragraph 116)
16. The Draft Workforce Strategy describes plans to improve workforce data. This is long overdue, and we will ask the Department and HEE to provide us with an update on these plans in six months' time. (Paragraph 117)
17. Sustainability and Transformation Partnership and Accountable Care System workforce plans need full scrutiny from HEE. This scrutiny should be carried out in a timely and transparent manner and take account of, and look to redress, shortages in community nursing. In response to this report, Health Education England must set out its planned timescales for undertaking this scrutiny, and we will expect it to supply us with a report of its scrutiny of STP workforce plans when they have been completed. (Paragraph 118)

## Annex 1: Note of discussions with nurses held by the Chair on 9 November 2017

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On 9th November 2017 the Chair of the Committee, Dr Sarah Wollaston, hosted two focus group sessions with nurses attending the Nursing Times Team Leaders' Forum, a conference for nursing team leaders from across the country, held at the Birmingham Hilton Metropole Hotel. Dr Wollaston was accompanied by two Committee staff members.

The nurses came from a variety of different organisations, specialties, and geographical areas. Some nurses were EU nationals. Each session lasted between 45 minutes and 1 hour, and each session was attended by between 15–20 nurses. Nurses attending supplied their names, email addresses and places of work.

### Session 1

#### *Staffing shortages, working conditions, impact on patient care.*

Nurses described significant gaps in nursing rotas – for example 20 staff for a rota of 30 – which can impact on patient care.

Staff were said to be making their own sacrifices as opposed to sacrificing patient care – for example not taking breaks, coming early, leaving late – but some gave the view that it did have an immediate impact on patient care, for example medicines not given on time due.

Nurses described the usual week at the moment of 55/60 hours. The group felt that sometimes finishing late was OK, but not continuously.

Nurses described chronic shortages of nurses – once a ward becomes fully staffed, staff will almost immediately be moved to cover another service,

Shortages then impact on retention, stress, physical exhaustion, musco-skeletal injuries.

#### *Recruitment*

Nurses described 'turf wars' for recruitment, with trusts giving students job offers earlier and earlier in their student careers, but they then leave as they change their mind. The process of employment also takes a while, as newly qualified nurses take a while to settle in as they have no experience, and not enough time or manpower to help them settle in as people are too busy. This can then result in new staff leaving.

When asked whether differential pay rates might help recruit nurses to particularly hard to recruit to specialties, an example was given where this had already been done, but this wasn't successful as the pool of nurses to recruit from was already too small

#### *Nursing associates*

The group did not feel that Nursing Associates would solve the current problems in the nursing workforce, and there was serious concern that this was going to be a replacement

to registered nurses as opposed to in addition. Nursing Associates will have different skill sets, and should free up nurses to do what only they can do, and also to develop skills to become specialists.

There was uncertainty about the accountability and regulation of NAs, and agreement on the need for clarity about what competencies they will have. Nurses were worried about their vicarious liability for NAs, if different trusts set different guidance on what they can and can't do. They also felt that there was a lack of consistent approach to training NAs

Many nurses reported that their organisations cannot find funding for backfill either for nursing associates or nursing apprenticeships. This was particularly the case in community care.

Nurses reported that they have no time to help and support newly qualified staff to develop, and then they leave, dissatisfied.

The group raised the disparity between nurses and doctors, as doctors have money and time in their contracts set aside for training and development. Nurses need time to develop into leaders. One nurse said “you are lucky if you can get released to go to a meeting, let alone a study day”

### ***Flexible working***

The group also pointed out that high vacancy rates also mean that organisations can't offer flexible working.

### ***Overseas nurses***

EU nurses reported that many of their colleagues from European countries have returned owing to uncertainty of their status. Recruitment from the EU is also becoming more difficult.

English Language tests required by the NMC were felt to be too difficult.

Transition also needed to be made a lot smoother for nurses arriving in the UK from the EU regarding admin, accommodation.

Nurses reported that in common with all new starters, it's very difficult to give nurses who have newly arrived from overseas proper support or induction because of staff shortages.

## **Session 2**

Nurses reported that there used to be lulls when they could recover and rebuild resilience following extremely busy periods- now that respite has gone

Nurses raised pay as a problem in recruitment and retention. Many mental health nurses go to the private sector as pay rates are higher. Nurses also felt that the pay does not reflect the responsibility of the posts, particularly in areas like critical care.

### ***Newly qualified nurses***

Nurses described how lack of experienced staff to support them leads to the loss of a lot of newly trained staff. There is also an expectation that newly qualified nurses can go straight into high risk services with a lack of experience or support. One nurse reported newly qualified nurses in her trust developing mental health difficulties owing to lack of support.

Many nurses felt that mentorship from experienced nurses should be made more readily available, to guide younger trainees.

### ***Working conditions***

Nurses described staff leaving because of burnout and workload. There was agreement that there is an urgent need for ‘more ‘hands on deck’ right now, even if it is HCAs rather than registered nurses, as there are simply not enough nurses to go around.

Nurses spoke of a high emotional toll, with fear of losing their registration everyday due to high pressure—one nurse said that ‘every time I walk on to the ward, my PIN is on the line’.

One nurse described how in her trust, nurses from relatively well staffed areas like critical care are now being asked to volunteer to staff wards which are understaffed. During night shifts there is frequently only one nurse on duty rather than the specified three. This means that the nurse can’t have a break, and can’t do certain aspects of patient care such as IVs.

Nurses described how now on a typical shift a far higher proportion of staff would be bank or agency rather than permanent staff, which is difficult as they may not be familiar with the ward or the team, and may need additional support, which is hard to find time to give.

Added pressure has also come because the demographics of patients have changed, older and need more care and attention than before.

Nurses argued that these factors can lead to more sickness and absence related to stress.

Nurses reported a lack of recognition for all their efforts, not paid for doing overtime or staying late, doing a lot on goodwill.

Nurses felt that CPD needed to help retention, but many organisations cannot offer CPD due to lack of manpower.

Nurses described a lack of facilities in wards for staff – for example no cutlery in staff rooms, no microwave etc. Nurses from one trust described working on winter wards which have no staff room, no cups for nurses to have a hot drink.

Nurses argued that these things contribute to them feeling undervalued.

Nurses described how when support, health and wellbeing initiatives are offered by the trust, they can’t use these because they don’t have the time.

### ***The positives should be championed***

However nurses were clear that the positive stories should also be told – of the cheer and care and kindness provided by nurses doing an incredible job. Some said they would still highly recommend the career as ‘the world is your oyster’.

### ***Overseas nurses***

EU nursing staff described feelings of great uncertainty, and not feeling welcomed. In their view messages from politicians have not reached the front line staff. They felt that a clear statement is needed setting out the future of EU nurses in the UK.

Nurses also argued that there were too many barriers to overseas staff coming to work in the UK, including language testing.

## Annex 2: Note of Committee visit to Royal London Hospital, Whitechapel, 23 November 2017

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On 23rd November 2017 the Committee visited the Royal London Hospital in Whitechapel, East London. The Committee heard directly from a large number of trainee nursing associates, and also from their supervisors, and from local and national leads for nursing workforce development.

The Committee then held a second, separate group discussion with around 20 nurses, which was organised by the Nursing Times. The nurses were from different backgrounds in terms of age, ethnicity and geography, and with a wide variety of job roles.

The Committee was represented by the following members:

- Dr Sarah Wollaston, Chair
- Ben Bradshaw
- Diana Johnson
- Andrew Selous
- Maggie Throup

### Discussion with Trainee Nursing Associates

#### *Introduction*

In general the TNAs the Committee heard from were extremely positive and enthusiastic about their training and the opportunity to train to become part of a new, regulated clinical profession.

Exposure to mental health nursing was a particular highlight for those who have not done this before – also inclusion of social care.

Those designing and leading this first pilot programme also said that they were fully open to taking all feedback on board and adapting the training programme as necessary.

#### *Backgrounds and future plans of TNAs*

All attendees had been recruited into the scheme from a healthcare assistant background. Some wanted the chance to progress their careers after qualifying as NAs. Others had joined the scheme because they wanted to get professional recognition for the job they already did. One was planning to work as a NA for at least two years before he considered training as a nurse. It was strongly felt that it would be impossible to begin training without a healthcare background. However, the group felt that there was a clear need for seamless career maps and clarity about regulation and APEL.



### *The role of the NA*

There was some confusion about identity of NA, even at a senior organisational level. One TNA described being asked “are you a HCA? Are you a student nurse?”. From a ward manager/ supervisor point of view, increased clarity is needed about the skills NAs will have on qualification – for example will they be able to do IVs?

Some felt that regulation was being done in a back to front way. One TNA said there were issues to clarify about whether they were supernumerary or not, and what their role was in relation to nursing students – why they can do some things that student nurses can’t do, and vice versa.

There was agreement that clarity about role and job title essential from a public protection point of view.

Some felt a distinct uniform would help achieve this clarity – a new uniform that celebrates their achievement.

### *Challenges within the training programme*

A TNA reflected on being thrown out of her comfort zone – which she welcomed – but felt that placements could be better prepared.

Issues were also raised about supervisors and mentors having too high a workload; and are not always well prepared. Some are not good teachers- for example someone who was unhappy about having to teach a TNA how to use a hospital bed – she had never worked in acute care before, so couldn’t be expected to know.

In some cases there is a mismatch with the university curriculum.

In some specialities (paediatrics) the TNAs are supernumerary, but in some they aren’t. One reflected that she didn’t have time to learn as her day job was so busy, despite being meant to spend 25% of her time learning. She wasn’t able to use her higher skill set (e.g. catheterisation, administering insulin) and could have learnt more on her ward but didn’t have the time.

There was discussion, although not consensus, about whether there should be specific mental health / adult pathways, or integrated.

The biggest challenge for managers is the fact that the roles the TNAs left behind have not been filled. This is not an expansion of the workforce, just upskilling the existing workforce. For example in paediatrics they have highly skilled TNAs, and are dealing with a very sick patient group, so they have to pay for backfill when the TNA goes on placement.

### *Practical difficulties*

Some practical difficulties were raised:

- Problems with London weighting on the periphery of London.
- Pay drops significantly when nightshifts stop

- Also challenging the other way round – when people move from 9–5 to shift patterns
- Little real pay progression for those who are already at the top of Band 3.

## Focus group session with nurses

### *Working conditions, increasing demand and complexity*

Nurses were clear that they want to deliver the best patient care that they can, but often return home after their work feeling that they have not been able to do so because of the demands placed on them while understaffed. At times they felt that staffing shortages in the face of increasing demand and complexity could have a negative impact on patient care. This can have a high emotional toll on nurses.

Nurses present described the realisation of newly qualified nurses that in practice they can't deliver the standard of care they were trained to deliver—they become disheartened as they can't deliver the basics of patient care, and in some cases leave.

Most nurses work an extra shift every fortnight—many felt at a point where they simply 'can't give any more'.

The nurses described the impact of increased complexity amongst the ageing patient population; so many patients attending A&E are very elderly with multiple conditions.

A nurse working in a day surgery setting described intense pressure to discharge patients—sometimes too early - meaning huge pressure is put on community nurses.

Community nurses described shortages meaning there are no colleagues to provide a second opinion; the impact of shortages in social care nursing, and other social care staff, also have a big impact on community nursing as there is so much overlap. One community nurse described how she would often go beyond the scope of her role when patients were in need of basic care or comfort, but this meant difficult choices, and as workloads were often so high, something would need to be left undone.

Changing mental health thresholds also mean there an increase in complexity of people's mental health conditions, again contributing to extremely challenging working conditions.

Nurses agreed that there needs to be different thinking about how care is delivered, with an increased focus on prevention and treating people in the community, but because of the 'relentless hamster wheel' nurses do not have the head space to make the change.

### *Nursing associates*

While nursing associates were welcomed, many emphasised that they are not a substitute for qualified nurses, but a support for them. For example, one nurse said how she is often on a bay with ten or eleven patients, when she's supposed to only have 6. A nursing associate would be a helpful addition, but what was really needed in that case was another qualified nurse to share her caseload. On the training of nursing associates, one nurse

mentioned how “trainee nursing associates are expected to learn on the job, but they don’t have the time. Student nurses are allowed that time. It’s really difficult to pull one person away to teach.”

### **Overseas nurses**

The group expressed concerns about EU nurses leaving, saying how they are “utterly reliant on nursing colleagues (from overseas) all of the experience and skills may disappear.” One nurse described how EU nurses are “gradually leaving due to uncertainty.” Moving onto nurses from outside the EU, there was a strong opinion amongst the group that the language requirements are too high.

### **Age profile**

A couple of the participants highlighted how the age profile of the nursing workforce poses a major problem for some services. One nurse described how her trust has one of the highest number of nurses over 50 in the country, with serious implications for the trust if it cannot replace this workforce as many begin to retire. The age profile for nurses in primary care was also highlighted, with one nurse commenting that roughly 50% of practice nurses are over 50.

### **Training and development**

Opportunities to learn, develop and progress, were very important to the nurses the Committee spoke too. One nurse described how “we don’t work in an environment where things stand still.” Development opportunities, either formal or informal, were seen by the nurses’ present as a sign that they are valued. However, the time available for staff to engage in these activities is limited. One nurse said how we “can’t even give a bit of love – tea, biscuits and a couple of hours training.”

Speaking about the student funding reforms, one nurse commented that: “there would have been nursing assistants who would have liked to go into nursing, but now can’t afford it.”

There was also a widely held view that the training system is too rigid. As one nurse put it there is “no facility to change your mind – I trained as a general nurse and then moved into mental health nursing. You can’t do that now. You’re losing people who have 10-years’ experience because they want to try something new.” A nurse from Portugal described how in Portugal newly qualified nurses become a general nurse first before they get their specialty. Most of the group agreed that the need to retrain before moving between specialties is a disincentive, and that more could be done to make the skills portable.

When asked about Magnet Hospitals—a scheme in the US that was raised during the Committee’s oral evidence—which aimed to give nurse more autonomy, there was a cautious welcome, but concerns about the costs involved. However, one of the nurses mentioned that modelling conducted by the Department of Health suggests that trusts would break even due to the positive impact Magnet has on retention.

## Formal minutes

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**Tuesday 16 January 2018**

Members present:

Dr Sarah Wollaston, in the Chair

Luciana Berger	Diana Johnson
Rt Hon Ben Bradshaw	Johnny Mercer
Rosie Cooper	Andrew Selous
Dr Caroline Johnson	Dr Paul Williams

Draft Report (*The nursing workforce*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraph 1 read.

Amendment proposed, to leave out the first paragraph in the table and insert the following new paragraph in the table:

‘There is no agreed measure of vacancies or the vacancy rate in the nursing workforce in England. There is also no agreement on how many nursing staff are required in areas except for critical care and paediatrics. Therefore working out how many vacancies there are is difficult. We also heard evidence that some hospitals put in regular adverts in case of a vacancy arising. Bearing this in mind, Health Education England estimate that there are 36,000 nursing vacancies in the NHS in England, equating to a vacancy rate of 11%, while the Royal College of Nursing give a figure of 40,000. There is a 9% nursing vacancy rate in social care. —(Dr Caroline Johnson.)

Amendment, by leave, withdrawn.

Paragraph 1 agreed to.

Paragraphs 2 to 118 read and agreed to.

Annexes agreed to.

Summary agreed to.

*Resolved*, That the Report be the Second Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Monday 22 January at 2.00pm.]

## Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

### Tuesday 7 November 2017

**Sir Robert Francis QC**, Chair, Mid Staffordshire NHS Foundation Trust Public Inquiry, Non-Executive Director, Care Quality Commission, and Honorary President, Patients Association

[Q1–13](#)

**Janet Davies**, Chief Executive and General Secretary, Royal College of Nursing, **Sharon Allen**, CEO, Skills for Care, **Daniel Mortimer**, Chief Executive, NHS Employers, and **Jane Beach**, Lead Professional Officer for Regulation, Unite in Health

[Q14–84](#)

### Tuesday 14 November 2017

**Lord Willis of Knaresborough**, member of the House of Lords Committee on the Long-term Sustainability of the NHS and Chair of the Shape of Caring Review, **Professor Brian Webster-Henderson**, Chair, Council of Deans of Health, and **Jackie Smith**, Chief Executive and Registrar, Nursing and Midwifery Council

[Q85–141](#)

**Claire Johnston**, Project Director, Capital Nurse, North Central London, and **Avril Devaney**, Director of Nursing, Therapies and Patient Partnership, Cheshire and Wirral Partnership, NHS Foundation Trust

[Q142–177](#)

### Tuesday 28 November 2017

**Professor Ian Cumming OBE**, Chief Executive, Health Education England

[Q178–227](#)

**Professor Jane Cummings**, Chief Nursing Officer and Executive Director, NHS England, and **Ruth May**, Executive Director of Nursing, NHS Improvement

[Q228–285](#)

Mr Philip Dunne, Minister of State for Health, **Professor Jane Cummings**, Chief Nursing Officer and Executive Director, NHS England, **Professor Ian Cumming OBE**, Chief Executive, Health Education England, and **Ruth May**, Executive Director of Nursing, NHS Improvement

[Q286–338](#)

## Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

NWO numbers are generated by the evidence processing system and so may not be complete.

- 1 Acorns Children's Hospice ([NWO0071](#))
- 2 Acqua Dolce ([NWO0044](#))
- 3 AIHO and NHSPN ([NWO0082](#))
- 4 All nurses.com ([NWO0011](#))
- 5 Attila Radi ([NWO0026](#))
- 6 Baroness Audrey Emerton ([NWO0122](#))
- 7 Barts Health NHS Trust ([NWO0129](#))
- 8 BDCFT ([NWO0005](#))
- 9 Bliss ([NWO0078](#))
- 10 Breast Cancer Now ([NWO0093](#))
- 11 Bupa UK ([NWO0115](#))
- 12 Capital Nurse ([NWO0090](#))
- 13 Care England ([NWO0062](#))
- 14 Care Quality Commission ([NWO0110](#))
- 15 Carlo Martin Posadas ([NWO0030](#))
- 16 Carter Consulting ([NWO0111](#))
- 17 Chartered Society of Physiotherapy ([NWO0094](#))
- 18 Cheshire And Wirral Partnership NHS Foundation Trust ([NWO0074](#))
- 19 Children & Young People's Mental Health Coalition ([NWO0072](#))
- 20 CLIC Sargent ([NWO0006](#))
- 21 Council of Deans of Health ([NWO0010](#))
- 22 Coventry University ([NWO0067](#))
- 23 Department of Health ([NWO0089](#))
- 24 Department of Health ([NWO0121](#))
- 25 Diabetes UK ([NWO0101](#))
- 26 Dr Elaine Maxwell ([NWO0055](#))
- 27 Dr Marion Lynch ([NWO0027](#))
- 28 Fraser Rigby ([NWO0008](#))
- 29 Grimsby Institute of Further and Higher Education ([NWO0023](#))
- 30 HCL Workforce Solutions ([NWO0056](#))
- 31 Jaison Sebastian ([NWO0016](#))
- 32 JSL Consultants ([NWO0025](#))
- 33 Liezl Camacho ([NWO0103](#))
- 34 London Higher (London Medicine & Healthcare) ([NWO0063](#))
- 35 Lukasz Warzecha ([NWO0035](#))

- 36 Macklin Care Homes ([NWO0059](#))
- 37 Macmillan Cancer Support ([NWO0087](#))
- 38 Marie Curie ([NWO0108](#))
- 39 Mental Health Nurse Academics UK ([NWO0045](#))
- 40 MHA ([NWO0051](#))
- 41 Miss ELLIE DODDS ([NWO0015](#))
- 42 Miss Vlatka Jovic ([NWO0029](#))
- 43 Mr Christopher Chambers ([NWO0009](#))
- 44 Mr Elmon Mathai Paul ([NWO0034](#))
- 45 Mr Febin Cyriac ([NWO0102](#))
- 46 Mr jithen benjamin ([NWO0019](#))
- 47 Mr Manuel Jr Cabrera ([NWO0061](#))
- 48 Mr Mark Defensot ([NWO0065](#))
- 49 Mr Pedro Lino ([NWO0020](#))
- 50 Mr Phil Hope ([NWO0047](#))
- 51 Mr Pravin Holkar ([NWO0050](#))
- 52 Mr Roderick Thirkell-White ([NWO0042](#))
- 53 Mr William Preece ([NWO0096](#))
- 54 Mrs Christine Dowling ([NWO0036](#))
- 55 Mrs Debbie Brown ([NWO0099](#))
- 56 Mrs Karen Hawksworth ([NWO0003](#))
- 57 Mrs Maria Biju ([NWO0080](#))
- 58 Mrs Soumya Philip ([NWO0043](#))
- 59 Ms Elisa Beardo ([NWO0040](#))
- 60 Ms Ellen Nicholson ([NWO0041](#))
- 61 Ms Orsolya Nyiri ([NWO0024](#))
- 62 Ms Vasanta Suddock ([NWO0104](#))
- 63 National Care Forum ([NWO0022](#))
- 64 National Mental Health Nurse Directors Forum ([NWO0075](#))
- 65 NHS Employers ([NWO0084](#))
- 66 NHS Improvement ([NWO0127](#))
- 67 NHS Partners Network & AIHO ([NWO0109](#))
- 68 NHS Professionals ([NWO0017](#))
- 69 NHS Professionals ([NWO0124](#))
- 70 NHS Providers ([NWO0076](#))
- 71 Nottingham University Hospitals NHS Trust ([NWO0007](#))
- 72 Nuffield Trust ([NWO0095](#))
- 73 Nurses from Nottingham University Hospitals ([NWO0128](#))
- 74 Nursing and Midwifery Council ([NWO0073](#))
- 75 Nursing Times ([NWO0058](#))

- 76 Overseas Nurses Currently Working In The Health Care Sector UK ([NWO0037](#))
- 77 Paediatric Continence Forum ([NWO0125](#))
- 78 Plymouth Hospitals NHS Trust ([NWO0021](#))
- 79 Professional Standards Authority ([NWO0069](#))
- 80 Professor Alison Leary ([NWO0100](#))
- 81 Professor Anne Marie Rafferty ([NWO0105](#))
- 82 Professor Jack Needleman ([NWO0032](#))
- 83 Professor Jennifer Hunt ([NWO0046](#))
- 84 Professor Matt Griffiths ([NWO0028](#))
- 85 Professor Vari Drennan MBE ([NWO0052](#))
- 86 Prostate Cancer UK ([NWO0106](#))
- 87 Rakhi M Kurian ([NWO0033](#))
- 88 Recruitment & Employment Confederation ([NWO0118](#))
- 89 Registered Nursing Home Association ([NWO0086](#))
- 90 Richard Twyford ([NWO0116](#))
- 91 RN, BSN, MSN, GNP-BC, CWOCN Jennifer Hurlow ([NWO0014](#))
- 92 Royal College of Nursing ([NWO0113](#))
- 93 Royal College of Nursing ([NWO0126](#))
- 94 Royal College of Psychiatrists ([NWO0092](#))
- 95 Sheffield Hallam University ([NWO0117](#))
- 96 Sir Robert Francis ([NWO0120](#))
- 97 Skills for Care ([NWO0091](#))
- 98 Stephane Guegan ([NWO0060](#))
- 99 Sussex Community NHS Foundation Trust ([NWO0070](#))
- 100 The Florence Nightingale Foundation ([NWO0079](#))
- 101 The Health Foundation ([NWO0097](#))
- 102 The King's Fund ([NWO0112](#))
- 103 The Open University ([NWO0012](#))
- 104 The Queen's Nursing Institute ([NWO0048](#))
- 105 The Royal College of Midwives ([NWO0066](#))
- 106 The Shelford Group ([NWO0114](#))
- 107 Together for Short Lives ([NWO0068](#))
- 108 UNISON ([NWO0038](#))
- 109 Unite the Union ([NWO0098](#))
- 110 University of Brighton ([NWO0054](#))
- 111 University of Southampton ([NWO0018](#))



## List of Reports from the Committee during the current Parliament

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All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

### Session 2017–19

First Report	Appointment of the Chair of NHS Improvement	HC 479
First Joint Special Report	Children and young people's mental health—the role of education: Government Response to the First Joint Report of the Education and Health Committees of Session 2016–17	HC 451

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