NMC submission for the inquiry into delivering NHS and care services during the pandemic and beyond

About us

1 As the professional regulator of nurses and midwives in the UK, and nursing associates in England, we work to ensure these professionals have the knowledge and skills to deliver consistent, quality care that keeps people safe.

2 We set the education standards professionals must achieve to practise in the United Kingdom. When they have shown both clinical excellence and a commitment to kindness, compassion and respect, we welcome them onto our register of over 700,000 professionals.

3 Once registered, nurses, midwives and nursing associates must uphold the standards and behaviours set out in our Code so that people can have confidence that they will consistently receive quality, safe care wherever they're treated.

4 We promote lifelong learning through revalidation, encouraging professionals to reflect on their practice and how the Code applies in their day-to-day work.

5 On the rare occasions that care goes wrong, or falls short of people's expectations, we can step in to investigate, and take action when needed. But we want to prevent something going wrong in the first place. So, we promote a culture that encourages professionals to be open and learn from mistakes, gives the public an equal voice and where everyone involved is treated with kindness and compassion.

Summary

6 We welcome the opportunity to respond to the inquiry into delivering NHS and care services during the pandemic and beyond. Our submission focuses on the questions of how to ensure that the positive changes that have taken place in health and social care are not lost as services normalise, how to meet delayed demand for health and care services following the emergency period, and how to meet the strategic challenges facing the sector as the UK descends the initial peak of the coronavirus pandemic, and prepares for a possible second wave.

7 In answering these questions we focus on the following areas:

7.1 Achieving parity across health and social care;

7.2 Meeting future workforce requirements;

7.3 The need for regulatory reform; and

7.4 Health and social inequalities faced by ethnic minority communities.

8 This submission is informed by our understanding and experience as the professional regulator of nurses, midwives and nursing associates, who continue to work at the forefront of efforts to tackle the pandemic and help services return to normal. We draw on insights from relevant research, feedback from our stakeholders, our own registration, revalidation and survey data, and insights from the measures we introduced at the beginning of the outbreak to regulate, support and expand the health and social care workforce. For further details of how we have responded to the pandemic, please refer to our previous submission to the committee for the inquiry into the management of the coronavirus outbreak.[1]

Achieving parity across health and social care

9 The coronavirus crisis has highlighted the vital role of health and social care services, not just in providing care and support for people when they need it most, but also for enhancing social cohesion and a sense of togetherness. The tradition of applauding all care workers every week is just one example of this.

10 However, it also exposed the wide and long-standing gaps that exist between the two systems. In normal times, the impact of this disparity on people who access services, as well as the professionals providing care was not always well understood. The pandemic has revealed that not only are these gaps far more systemic than we may have previously recognised, but that they also pose life-threatening risks for those who use social care services and for social care employees, which includes approximately 44,000 nurses across the UK.[2]

11 Though the UK entered lockdown on 23 March, it was not until the end of April that the Government in England started to include deaths that had occurred outside of hospitals in their daily reports, and an action plan for social care was published. We are also aware that concerns around the availability of testing and appropriate personal protective equipment (PPE) have presented additional challenges and uncertainties for social care workers, including nurses.

12 Workforce estimates for England suggest that nursing vacancy rates are currently similar across the NHS and the social care sector, with both standing at 9.9 percent according to latest figures.[3] But while the number of nurses in the NHS in England has grown from 309,000 in March 2013 to 325,000 in March 2019,[4] in social care in England they have fallen by nearly a fifth, from 44,000 to 36,000 over the same period.[5] In previous years, services might have been able to manage this reduction in nursing staff by relying more on the wider care team, but with fewer nurses with the training and expertise to effectively control infections

[1] NMC response to the Management of the Coronavirus Outbreak Inquiry

[2] See workforce estimates at Skillsforcare (England); Social Care Wales; Scottish Social Services Council and the Department of Health (Northern Ireland)

[3] NHS Vacancy Statistics England as at March 2020; Skills for care, workforce estimates as at March 2019

[4] NHS Workforce Statistics - February 2020

[5] Skills for care, workforce estimates as at March 2019

and support people with respiratory diseases, this may have been harder during the peak of the pandemic.

13 Poor retention is another key factor. With over a third of employees leaving their roles each year,[6] social care nursing has a turnover rate that is almost three times higher than that of the NHS.[7] This has led to a high use of temporary, bank or agency staff. As these employees often work across multiple sites and do not have the same access to sick pay, this is likely to have presented further difficulties in managing the spread of coronavirus infections.

14 As a result of these issues, reports suggest that deaths among care home residents make up around half of all deaths associated with Covid-19 in England,[8] and that deaths among people with learning disability or autism have more than doubled during the pandemic.[9] They may also account for the higher rate of deaths among social care workers, which for male employees is 64 percent greater than for those working in hospitals, and 162 percent higher than for the general working-age male population.[10]

15 The ongoing crisis has illustrated the urgent need to close the gaps between health and care services, especially around staffing levels and skill mix, investment for training and resources, and around data and intelligence. Achieving parity between these two sectors is critical for making sure there are enough qualified nurses in social care settings and that the people who depend on these services are provided with safe, compassionate and dignified care. For further details of our priorities and recommendations around social care, please refer to our written submission to the HSCC inquiry earlier this year.[11]

Meeting future workforce requirements

16 Earlier this month we reported that the number of nurses, midwives and nursing associates on our register had risen to 716,607 as of 31 March 2020 - a rise of 18,370 (2.6%) over the previous 12 months.[12] Despite this growth, as we entered the coronavirus crisis there were still serious shortages across the health and care sectors, especially in specialist areas such as mental health, community and learning disability nursing, as highlighted by the overall vacancy rates cited above of just under 10 percent.[13]

17 The UK's departure from the EU continues to present a significant risk of exacerbating recruitment and retention challenges. Data from the NMC register suggests the 2016 referendum may already have had an impact on the wider nursing and midwifery workforce across the UK, with a rise in the number of EU-

[6] Ibid
[7] NHS, The national retention programme: two years on
[8] LTCCovid, England: Estimates of mortality of care home residents linked to the COVID-19 pandemic
[9] CQC publishes data on deaths of people with a learning disability
[10] ONS, Coronavirus (COVID-19) related deaths by occupation, England and Wales
[11] NMC response to the Social Care Inquiry from the Health and Social Care Select Committee
[12] The NMC Register - March 2020
[13] Record numbers of registered nursing and midwifery professionals but potential stormy waters ahead, warns NMC

trained nurses and midwives leaving our register since 2016, and a sharp drop in the number of new joiners.[14]

18 The fall in numbers from the EU over recent years has been counterbalanced by a rise in internationally-trained nurses and midwives, which follows a number of changes we made to improve and streamline our international registration processes. However, protective measures imposed by countries in response to the global pandemic, both here and abroad, may threaten future international recruitment efforts.

19 Rapidly growing the nursing and midwifery workforce in a safe and measured way has been a key focus of the NMC's response to the coronavirus outbreak. To this end, we introduced temporary registration to certain eligible groups of nurses and midwives. This measure has resulted in over 14,000 additional nurses and midwives able to support the UK's efforts to control the spread of the virus and provide care to people with the disease. However, evidence suggests that a majority of nurses and midwives who started temporary registration have not yet been deployed. An analysis of our own survey of temporary registrants from June 15 found that in England just 31.5 percent of people who responded had begun practising.

20 Though cases of coronavirus are falling, there are a number of reasons why it will be critical to maintain an expanded workforce beyond this current emergency period. Firstly, the demand for coronavirus-related care is beginning to be replaced by 'pent up' demand for services and clinics that have been closed or reduced due to national lockdown measures. Secondly, a second wave, or a series of local spikes of coronavirus infections, still remains a possibility, especially over the winter months. Finally, the physical, mental and emotional 'burnout' experienced by nurses and midwives who have been working in extremely pressurised and sometimes distressing circumstances caring for people with coronavirus must be taken into consideration. With research suggesting that nearly a third of nurses and midwives are experiencing depression, anxiety or stress as a result of Covid-19,[15] minimising the added pressure of staffing shortages will be essential for allowing health and care professionals to continue delivering high quality, safe and effective care.

21 We are currently working with the Department for Health and Social Care (the Department), NHS England / Improvement (NHSE/I) and the devolved administrations, to ensure that all of these factors are considered as we transition out of the emergency period, and as emergency powers introduced to expand the workforce, including temporary registration, are ended. We believe it will be critical to avoid a sudden 'cliff edge' drop in temporary workforce numbers, which could destabilise health and care services as they begin to return to normal service provision.

22 For our part, we are exploring how to support temporary registrants to meet our requirements for permanent NMC registration. Our survey analysis also found that 61 percent of people with temporary registration in England would consider, or are

[14] NMC, Registration data reports
[15] KCL, Survey of UK nurses and midwives' highlights their concerns about health, training and workload during COVID-19

highly likely, to apply for permanent registration. We are currently working with the wider sector to help these people overcome any unnecessary barriers to meeting our requirements. We continue to be guided by our vision of 'safe, effective and kind nursing and midwifery practice', and as such, we are committed that we will not undermine our existing standards for entry or re-admission to the register.

23 Facilitating the deployment of nurses and midwives with temporary registration is one of the ways they can be supported to return on a permanent basis. We are currently working to better understand the deployment data we have received as part of our survey of people on temporary registration, and we will be keen to share this with key stakeholders in order to help people to meet the practice hours required for re-joining the NMC register permanently.

24 We have also been working with our partners to support the reopening of the Objective Structured Clinical Examination (OSCE) test centres, which were able to resume services on 20 July. These will allow nursing and midwifery professionals trained outside the EU to complete their tests in a safe, socially distanced way and meet a key permanent registration requirement.

25 Prior to the lockdown, we had been working closely with the three OSCE centres to allow more overseas applicants to take their tests. Centres can open for longer days, for more days over the week, and with increased weekend provision. Additionally, two centres have refurbished their facilities, effectively doubling their capacity. As a result of these changes we believe there is now sufficient capacity to support the long-term targets around international recruitment set by NHSE/I. However, we intend to keep this situation under review, and will be considering a range of factors, including capacity, geography and flexibility, when the current OSCE centre contracts are re-tendered in February 2022.

26 There is also an urgent need to address more longstanding workforce issues, in particular around retaining new and existing staff. Key to this will be ensuring that nurses, midwives and nursing associates are able to access the ongoing support, training and development opportunities they need throughout their careers. While last year's Interim NHS People Plan provided a welcome commitment to improving levels of retention, we look forward to the publication of the final People Plan, which we hope will include comprehensive, detailed and fully costed proposals for achieving this goal, and placing the nursing workforce on a more sustainable footing.

The need for regulatory reform

27 Many of the measures we took in response to the outbreak of Covid-19 required changes to our governing legislation.[16] These included amending the Nursing and Midwifery Order 2001 to enable temporary registration, through emergency powers provided by the Coronavirus Act 2020.[17] These changes, and the subsequent steps we have taken as a regulator, have illustrated the capacity for

[16] NMC, Our legislation
[17] The Coronavirus Act 2020

permissive and flexible legislation to empower regulators to act in a responsive yet safe and proportionate manner.

28 However, it is apparent that we were only able to take these steps because the Government enacted emergency powers to allow this flexibility. We could not have responded in the same way within our existing legislation.

29 In addition to these changes, we also amended our Registration Rules to allow us to extend revalidation dates and carry out remote registration appeals; our Fitness to Practise Rules to allow us to conduct hearings remotely; and our Practice Committees Constitution Rules to allow us to flex the quorum of our Fitness to Practise panels. Though we were able to make these changes ourselves, through the Nursing and Midwifery Council (Emergency Procedures) (Amendment) Rules 2020,[18] they first needed to be approved by the Department of Health and Social Care and the Privy Council. This meant that the process took longer than would otherwise have been necessary.

30 In its current form, our legal framework is highly prescriptive and contains a significant amount of unnecessary procedural detail. Amending our legislation can take up to two years, involving a lengthy period of collaboration between us and the Department, and parliamentary and Privy Council approval. As such, our legislation does not allow us to react with the speed and flexibility that is required of a modern regulator. As well as responding to future emergencies with speed, flexibility and autonomy, taking in lessons from Covid-19, we need to be ready to innovate and adapt to the constantly evolving health and social care environment in which we operate.

31 It is clear regulatory reform is needed to deliver this. To that end, we are continuing to engage with the Department on what our future legislative model should look like. Some of the changes we would like to see as part of a reform programme include replacing the ten separate statutory instruments that set out how we regulate with a single high level piece of legislation; providing us with powers to set our regulatory requirements in our own rules, policies and guidance; and allowing us to determine the structure and operation of our register, so that it provides clarity for the public about who is caring for them and better supports the workforce.

Health and social inequalities faced by ethnic minority communities

32 One of the clearest and most urgent lessons to emerge from the coronavirus crisis is the need to address the reasons for its disproportionate impact on people from ethnic minority backgrounds. Health and social inequalities have been further underlined in recent months by the global impact of Black Lives Matter, which has brought attention to racial discrimination and injustice more broadly. As we start to resume wider health and care services, and prepare for a potential second wave

[18] The Nursing and Midwifery Council (Emergency Procedures) (Amendment) Rules 2020 Order of Council 2020

of coronavirus infections, we believe it is important for us to do what we can to tackle these issues head on.

33 We are guided in this respect by our statutory duty to eliminate discrimination in our own processes and by our wider responsibility to use our regulatory powers to promote fairness and equality. Furthermore, in our new five year strategy we have committed to both championing the values of equality, diversity and inclusion, and to improving how we use and share our insights and intelligence, including in relation to our own registration data.[19] We are determined not to lose sight of the lessons of recent months, but to keep them at the fore as we pursue these long term commitments.

34 Throughout the pandemic, evidence has shown that people from ethnic minority backgrounds are significantly more likely to face negative outcomes, including death, as a result of Covid-19. Analysis from the ONS has found that black people in England and Wales are more than four times more likely to die from a coronavirus-related cause than their white counterparts. Bangladeshi, Pakistani and Indian people, and people with mixed ethnicities were also found to have significantly higher odds of death, compared with people with a white ethnicity.[20]

35 A Public Health England (PHE) review of excess mortality found a similar pattern. Death rates during the period of the pandemic have been four times higher than expected among black men, almost three times higher in Asian men, but just two times higher among white men.[21]

36 Some of the factors behind these gaps are as yet unexplained, but it is clear that wider health and social inequalities are relevant. Both the ONS and PHE reports suggested that the disparities were likely to be explained partly by the risk of working in certain occupations, including social care roles, and by wider health inequalities.

37 We also know from our revalidation data that there are clear differences in ethnic diversity across different roles and sectors.[22] People who identified as belonging to a non-white British background accounted for almost two-thirds of those employed via an agency (65 percent) and over half of those employed in the care home sector (51 percent). As set out above, these roles often have the poorest pay, conditions and development opportunities, and have the highest risk of exposure to Covid-19. This provides further rationale for the need to address the issues facing social care outlined in the sections above.

38 In 2017 we published research carried out by the University of Greenwich,[23] which highlighted that a disproportionate number of ethnic minority professionals are referred to our fitness to practise services by their employers. We have since used the insights gained from this research to ensure our fitness to practise processes look deeper into the context in which incidents occur, and have worked with employers and partners to identify discrimination across the sector. Our aim is for

[19] NMC Strategy 2020-2025
[20] ONS, Coronavirus (COVID-19) related deaths by ethnic group, England and Wales
[21] PHE, Disparities in the risk and outcomes of COVID-19
[22] NMC, Revalidation: Year 3 Annual data report
[23] NMC, The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process

our work on including contextual factors to continue to provide invaluable insights for us and our partners across health and social care, and to inform and influence long term solutions.

39 We have also begun a new programme of research to build on this existing evidence base. This will look at more of our processes and the ways in which they impact on nurses, midwives and nursing associates with different protected characteristics. We will be publishing the first stage of this work in October. Further work including the actions we will take in response to these findings, will be informed by the advice from our expert advisory group comprising stakeholders from across the UK, and by insights from the Black Lives Matter movement and Covid-19.

40 Recent months have taught us that the immediate and longer term challenges facing health and social care are highly connected, and as such cannot be properly understood or engaged with as separate issues. As we start to transition out of the current emergency period we recognise that we have an opportunity and a responsibility to make sure the system as a whole is built on a more equitable and sustainable foundation, in terms of all of the key issues outlined above.

41 But we also acknowledge that the NMC plays just one part in the wider health and social care landscape. We are therefore keen to use our data, our insights and our influence to continue working in collaboration with regulators, governments and other organisations across the four UK countries to meet this broader challenge and ensure that we are better in a position for the future.

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