HEE call for evidence: Long term strategic workforce review

Thank you for the opportunity to make an initial submission to this important piece of work being led by Health Education England. It is a great opportunity to think about how we all work together to achieve genuinely strategic workforce planning.

We have a keen interest in this work, as the 732,000 professionals on our register are the largest component of the workforce, and they are responsible for so much of the day to day care that shapes the experiences and outcomes of people using health and care services.

We are also uniquely placed to comment on the whole nursing workforce, not just those who work in the NHS. We are delighted your remit includes social care, as it is not possible to make a sensible assessment of stocks and flows in nursing without acknowledging that many nurses (and increasingly, nursing associates) will choose to work in social care. The pandemic has served to reinforce the interdependency of health and social care, and the need to focus on the care people need, not the site of delivery. Excellent nursing in care settings is good for the people who use social care, and it eases pressure on health settings.

We welcomed the recognition in the People Plan that the issues in nursing and midwifery were the most acute facing the NHS and that addressing shortages in our professions was the priority for government. The government's pledge to attract 50K more nurses by 2025 is also welcome.

We would like the framework to promote a vision for how regulation can support the workforce we want and need. This vision could usefully inform the government's regulatory reform agenda, ensuring there is alignment between our vision for the workforce and the updated powers and responsibilities given to regulators.

We are already doing a lot of work together on the exchange of workforce data and insights, and we are finalising a data sharing agreement that will enable us to exchange data with HEE's supplier working on workforce modelling (the Health Foundation/DAS project).

Our response

We are better placed to comment on some of the drivers for change you have identified than others, and so we have not attempted to do justice to your detailed call for evidence, but we set out our thoughts on **five critical factors** in strategic workforce planning.

1. Assess the risks associated with our current workforce

An important starting point is to identify where the composition of our current workforce leaves us vulnerable. There are now almost 732,000 nurses, midwives

and nursing associates on our register, an increase of over 15,000 since last year.[1] Almost 577,000 of those are based in England.[2]

We have seen improving retention, with a reduction in the number of people leaving our register for the fifth year running. However, the number of people joining our register for the first time is lower than in 2019-2020. Our registration data[3] indicates an overall increase of 4.6 percent in the number of professionals joining our register since 2017. Of those people joining our register for the first time, this has increased by 16 percent between the period 2016-2017 (20,014) and 2020-2021 (23,224). The number of people leaving our register has declined by 27.8 percent over the same period.

We are more reliant than many other countries on overseas trained nurses and midwives – according to the Health Foundation, more the double the OECD average.[4] As illustrated in our statistics,[5] 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. Nonetheless, we are vulnerable to changes in migration or labour market forces, or to further pandemics affecting the movement of the global workforce. We will continue to be reliant on overseas registrants for the immediate future, but we must build an approach to workforce planning that is rooted in stronger domestic supply and retention.

Workforce estimates for England suggest differences in nursing vacancy rates are higher in social care than in the NHS. The latest statistics indicate a registered nursing vacancy rate of 9.2 percent in the NHS (as of March 2021) and 12.3 percent in social care (2019-2020).[6] [7] There is also a considerably higher turnover rate for nurses in adult social care (41.3 percent) compared to those in the NHS (9.4. percent).[8]

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[1] NMC (2020), The NMC register: 1 April 2020 – 31 March 2021. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/annual-2021/0005b-nmc-register-2021-web.pdf

[2] Figure excludes the role of nursing associate, which was introduced in 2019. NMC, The NMC register
England: 1 April 2020 – 31 March 2021. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/annual-2021/0005c-nmc-england-register-2021-web.pdf

[3] Registration data reports available here: https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/

[4] The Health Foundation (2020) Building the NHS nursing workforce in England. Available at: https://www.health.org.uk/publications/reports/building-the-nhs-nursing-workforce-in-england

[5] Ibid.

[6] NHS Digital (2021), NHS Vacancy Statistics: Registered nursing % vacancy rate. Available at: http://digital.nhs.uk/pubs/vacancystatsApr15Mar21

[7] Skills for Care (2020), Adult social care workforce estimates: Table 4.13. Estimated number of vacancies in the adult social care sector. Category of nurse registration. Available at: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Workforce-estimates.aspx

[8] Skills for Care (2020), The state of the adult social care sector and workforce in England: October 2020. Available at: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf

The overwhelming majority of nurses and midwives are women, meaning that we are not reaching a considerable pool of potential health and care professionals. Nor are we achieving diversity in positions of seniority, meaning that we are not making full use of the talent available to us. A significant number of the professionals on our register will be retiring over the next decade, and we are not on the whole good at providing suitable opportunities for people towards their careers end so that we retain their expertise.

2. Focus locally and regionally

We are encouraged by the role being given to Integrated Care Systems to act on education, training and workforce at the local and regional level, bringing together education, health and care providers to pool insights and identify opportunities. Most of our registrants are mature entrants to their professions, and as such many have ties to their locality. In every locality there is a pool of people within the health and care assistant workforce with the potential to progress to registered professions with the right pathways and support.

For example, there are hundreds of people now training to become nurses who would not have done so without the intermediate opportunity of nursing associate programmes, through which they have proved their ability and tenacity. The advent of the nursing associate opportunity is now focusing employers on their talent pipeline – for example, addressing basic skills needs of their HCAs so that in time they can access foundation degree level programmes. At the government's request, we designed the nursing associate role to be a stand-alone role in its own right and a progression route to degree level nursing. For this reason, we need to aim for an oversupply of nursing associates if we want a critical mass of NAs in order to explore how the role can add value in different settings, recognising that a subset of every cohort will not remain as nursing associates. Not all nursing associates with the ability and desire to progress have found it straightforward to gain access to a suitable RN programme, so further work is needed to smooth this path.

Apprenticeship is not a cheap or quick route to our register, but it is an important option in the mix, for those who cannot afford to take a break in earning in order to participate in full time education. With the health and care sector being such a major national employer, and with apprenticeship levy funds sitting unspent while providers are short of money and staff, it would be good to see this review focus on how the sector might more actively shape the national apprenticeship approach that meets our sector's needs.

We have yet to understand the long term impact of the pandemic on local and regional labour markets. It is encouraging that applications to our professions were up this year, no doubt influenced by the positive national response to the work of health and care professionals through this extraordinary period. It is possible that remote working might persist for many employees, and this could mean there are more and diverse employment opportunities in parts of the country where health and care were previously almost monopoly employers. With women so dominant in our professions, we are particularly vulnerable to competition from modes of employment

that allow more flexibility to balance work and caring responsibilities of different sorts. We know from our leavers' survey that inflexibility is a push factor – it can also be factor influencing decisions about where to practise, with agency and in many cases the community and care sectors offering more manageable work-life package than some NHS settings.

3. Pay attention and plan interventions across the course of careers

There is no 'silver bullet' to tackle retention but there are known pinch points across the career course, each of which will benefit from attention and action.

- Understanding and tackling the reasons for **student attrition**.[9] [10] – including addressing additional living costs, and poor clinical experiences.[11]
- Ensuring new entrants to our professions have the support and time to maintain and enhance the standards they have demonstrated as students. We have issued guidelines on **effective preceptorship**, which is effective at reducing early attrition and, as demonstrated in the RePAIR[12] report, cost effective.
- Giving experienced professionals structured **opportunities to update and upskill** – our standards of proficiency and revalidation can be good tools to this end
- **Specialist and advanced practice** can be effective retention strategies as well as good for people who use health and care services – giving excellent nurses, midwives and nursing associates the chance to learn and contribute more. Routes to specialist and advanced practice should be structured, clear and more equitably available.
- **Opportunities for experienced professionals** to evolve new roles in the later stages of their careers, to avoid 'cliff edge' ends to working life, and make good use of their expertise.

4. Make the health and care service a great place to work

Health and social care can be uplifting and rewarding places to work, but we know from our surveys, among other sources, that for too many nurses, midwives and nursing associates, poor workplace culture is a factor that drives people out. This includes experiences of bullying, discrimination, and blame culture. In our leavers'

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[9] The King's Fund (2019), Closing the gap. Available at: https://www.kingsfund.org.uk/sites/default/files/2019-06/closing-the-gap-full-report-2019.pdf

[10] Royal College of Midwives (2018), Blow off course. Available at: https://www.rcm.org.uk/news-views/rcm-opinion/blown-off-course/

[11] The Health Foundation (2018), One in four student nurses drop out of their degrees before graduation. Available at: https://www.health.org.uk/news-and-comment/news/one-in-four-student-nurses-drop-out-of-their-degrees-before-graduation

[12] HEE (2018) RePAIR: Reducing Pre-registration Attrition and Improving Retention Report

survey, poor culture was the fourth most frequently selected reason for leaving our professions, with one in five respondents (18.1 percent) citing this as a reason for leaving. [13]

It can also affect patient safety. The recent Health and Social Care Committee report on maternity safety in England identified the presence of a persistent culture of blame in multi-disciplinary maternity teams as a root cause of unsafe practice.[14]

There is an established evidence base on the impact of leadership on outcomes for professionals (well-being, employee engagement, turnover and absenteeism) and for patients (satisfaction, patient mortality and overall quality of care). Research on leadership in nursing indicates strong links between management practice and key indicators, such as retention, turnover and job satisfaction.[15]

We will retain a diverse workforce if we make sure that health are safe, fair and kind places for people with protected characteristics to forge their careers and thrive in their professional lives.

5. Anticipate the future and prepare our professionals

We would benefit from a periodic opportunities to assess future knowledge and skill needs on the part of our workforce. Identifying topic areas is one part of the challenge; ensuring that meaningful opportunities reach a workforce of this size and complexity is arguably harder.

Nurses, midwives and nursing associates are at the front line of care and people who rely on them rightly expect them to be up to date, but their access to quality CPD is not guaranteed and resources are insufficient. We need to secure investment in CPD as well as identify the right topics and priorities. At the NMC we have recently developed new standards of proficiency for our three professions, informed by extensive dialogue about what people believe future practice will need to look like. These exercise led us to strengthen the following emphases in our standards:

- Commitment to understanding and tackling health inequalities
- Proficiency in providing care to people with mental and physical ill health
- Empowering the people receiving care, recognising their expertise and enabling them to ask questions, understand implications and make decisions

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[13] NMC (2020), Leavers' survey 2020. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/leavers-survey-2021.pdf

[14] House of Commons Health and Social Care Committee (2021), The safety of maternity services in England: Fourth Report of Session 2021–22. Available at: https://committees.parliament.uk/publications/6578/documents/73151/default/

[15] The Kings Fund (2015), Leadership and Leadership Development in Health Care: The Evidence Base. Available at:

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf

- Receptivity to new technologies and emerging science
- Capabilities in respect of health promotion and prevention
- Inter-disciplinary working within and beyond health and care

Our latest standards of proficiency for our professions seek to address these needs, but we cannot overload pre-registration because it is the only guaranteed education of professions receive. Revalidation is now well established for nurses, midwives and nursing associates, and sets an expectation that professionals take responsibility for maintaining their knowledge and skills. It is time to support all employers to make lifelong learning a reality for our workforce.

Pandemic learning and recovery

The NMC worked closely with the government in early 2020 to expand the workforce in response to the Coronavirus pandemic by establishing a temporary register. As of 31 March 2021, there were 12,382 temporary registrants based in England.

We can see the value in retaining the temporary register for the immediate future. The pandemic is not over and though vaccines are successfully reducing rates of mortality and serious illness, we do not know how effective they will prove in response to new variants, and we are only beginning to understand what long Covid will mean for those affected, and the professionals who treat them. There is also an argument for sustaining additional capacity in the knowledge that the pandemic has created a backlog of non-Covid-related treatment.

Our engagement suggests that the majority of those who took up temporary registration in England would consider returning to the register. We are working on facilitating a route for them to do so.

Workforce planning must consider how we can be well prepared to mobilise additional capacity – including how we maintain a level of competence in practitioners for roles the may need to step into in an emergency, and how we deploy people effectively out of their customary roles without undue risks to public protection.