HOUSE OF COMMONS

Health Committee

Oral evidence: Nursing Workforce, HC 353

Tuesday 7 November 2017

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Rt hon. Mr Ben Bradshaw; Dr Lisa Cameron; Dr Caroline Johnson; Diana Johnson; Andrew Selous; Maggie Throup; Dr Paul Williams.

Questions 1 - 84

Witnesses

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

II: 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.

Written evidence from witnesses:

- Sir Robert Francis QC
- Royal College of Nursing
- NHS Employers
- Unite in Health

Examination of Witness

Witness: Sir Robert Francis QC.

Q1 **Chair:** Sir Robert, we welcome you back to the Committee.

Sir Robert Francis: It is a pleasure to be here—I hope.

Chair: For those who are following this issue for the first time from outside this room, would you mind setting out your experience with the Mid Staffordshire inquiries, which you led, and your role with the Patients Association?

Sir Robert Francis: As people will know, I was asked to chair two inquiries into Mid Staffordshire. I found that, collectively, a disaster was allowed to happen because of a number of things. The priorities of the organisation were skewed by the policy imperatives of the time to allow it to forget that its real job was to look after patients. At the time, achievement was seen as becoming a foundation trust. That appeared to require, not intentionally by those who created the foundation trust, largely preoccupying itself with structures and so on rather than listening to the people in that organisation. They did not listen to the patients either, and disregarded complaints and mortality statistics. When I say "disregarded," there was a culture of looking for positive news and ignoring the bad, and finding reasons why that was not as bad as perhaps it might be. That led to a lot of suffering and in the end—symbolically, only last week—Mid Staffordshire NHS Foundation Trust being dissolved. Therefore, starting from what could probably have been sorted out relatively easily, it became a disaster.

In relation to what you are thinking about today, one of the things that happened, almost without anyone noticing, was that over a period of time nursing staff were reduced in order to save money. It did not all happen in a big lump; it happened over a period of time. Concerns were expressed by regulators about the adequacy of the nursing staff, and when eventually it was decided that probably there was something wrong with the nursing numbers it took a very long time to do anything about it, and at the time of my inquiry the remedy for that was still happening.

After that, notoriously, I made quite a few recommendations, some of which are relevant in this area and I put in my statement, but what I was really after was a culture change—putting the patient first and transparency, openness and candour. I am happy to say that I think some of that at least is happening.

Relevant to this inquiry, I was then asked to chair a review of whistleblowing in the NHS, which I prefer to call "freedom to speak up," and I did not find a very happy picture of that, either. I made various recommendations about how staff could be encouraged and supported in speaking up and ensuring something was done about the concerns they

raised. Some of that is happening, although I believe there is a long way to go.

That led me to retain an interest. I am president of the Patients Association. Although that is an honorary position, you can see from my statement that, to my relief, it approves of what I say.

I am a non-executive director of the Care Quality Commission. I should emphasise that I do not speak for it today. Within that organisation, one of my responsibilities is to chair the accountability and liaison board for the National Freedom to Speak Up Guardian.

In terms of what you are interested in today, I believe we do have a crisis. I am not sure how it is going to be fixed in the short term, but I am confident that something needs to be done about the working conditions of NHS staff generally, but perhaps nurses in particular.

Q2 **Chair:** Thank you very much for that overview. We will come to that final point in more detail later but, drawing on your experience of chairing the inquiries and your role in representing patients, will you set out what impact a shortage of nursing staff has on patients?

Sir Robert Francis: As I have said in my statement, 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.

In that context, at Mid Staffordshire I heard the most horrific stories of patients being neglected, left in unclean beds in their own faeces and in effect ending up dying in indignity rather than peace. It is not just a question of safety in a strictly medical sense, although I believe that to be important; it is the surroundings in which a patient is looked after and kept safe and feels safe. Without all that support, a visit to a hospital is a traumatic experience rather than one that has optimism in it.

Q3 **Chair:** Have you seen the report out today from NHS Providers about the workforce?

Sir Robert Francis: Yes, I have.

Q4 **Chair:** It highlights that, when asked about the most pressing challenge to delivering high quality healthcare at the trust, workforce came out as No. 1. Do you agree with that assessment?

Sir Robert Francis: Yes. The workforce is what makes care work. You can have a lot of very smart equipment; you can have a very smart foyer at your hospital; you can even have a car park with enough room for people's cars to park in it; but unless you have properly trained and

caring staff who espouse the right values and have the time to do what they need to do—a very important feature—the service will deteriorate.

Q5 **Chair:** Do you think there is a danger that we have come full circle, with patient safety again being put at risk by a shortage of nursing staff?

Sir Robert Francis: Fortunately, the Government still demonstrate their concern about patient safety—a number of encouraging steps are being taken in that regard—but what I see as a bit of a circle is that at the time of Mid Staffordshire there was huge pressure on organisations to balance their books, make productivity improvements and matters of that nature. It became all about the figures in the books rather than the outcome for patients, and I believe there is a danger of that happening again.

Q6 **Dr Williams:** What is your view on the work that has been done to date on safe staffing levels guidance?

Sir Robert Francis: Thank you for asking me that. As you know, I recommended that there should be research and evidence-based work produced by NICE in relation to guidance. The reason why I did it was because I was rather surprised in the course of my inquiry to find no consensus or agreement as to what a safe level of staffing was in any given situation. Therefore, I welcomed the work that NICE was asked to do. I expressed concern when the work was removed from NICE and it eventually ended up with NHS Improvement. I followed with interest the production of what I say in my statement was information resource. I meant improvement resources, which is what they are called. I am glad they are called that rather than guidance, because in my view they do not quite amount to guidance.

My test for something that would be effective—I am not saying it does not have its uses—is to have some document, perhaps guidance, which, if I were a non-executive director on a hospital trust board, would enable me to tell whether what my nursing director, medical director and, I am afraid, finance director was telling me was a safe system was in fact safe. Improvement resources are helpful at pointing to various toolkits and so on, but they do not really tell you what the answer is. I appreciate that the answer will be different in different circumstances.

There is nothing in those documents with which I would intrinsically disagree in terms of things to be concerned about. I know that NHS Improvement is encouraging further research to try to produce the evidence that seeks to find the association between, for instance, hours of care and outcomes, but at the moment we do not seem to have that. It is of concern that we have not got further in finding out that piece of knowledge. This is necessary work, so I regard the improvement resources as a step on a journey rather than the final answer.

Q7 **Diana Johnson:** Wales has taken a different approach and introduced a statute: the Nurse Staffing Levels (Wales) Act 2016. As I understand it, in adult acute care settings an appropriate nurse staffing level must be

calculated and maintained, and health boards have a duty to report on compliance. What are your views on that approach, which is different from the one the Department of Health and NHS are taking at the moment?

Sir Robert Francis: Forgive me if I am wrong, but I understand it does not prescribe a number or ratio.

Diana Johnson: It does not; there is flexibility for each organisation.

Sir Robert Francis: I am absolutely in favour of transparency about how organisations calculate their workforce. I take the point that it is not just nurses, in the sense of registered nurses, but ancillary support staff as well. If I may, I might have a word about that in a moment. At the moment, they are required to publish their planned workforce and the actual workforce, but that does not really answer the question whether the planned workforce is what is needed for patients. We probably need to be asking for more in that regard so that the public, patients and perhaps bodies such as yours can hold trusts to account. At the moment, it is very vague. It is possible for what happened at Mid Staffordshire—a slow degradation of the staffing resource—to happen without anyone noticing, and that is a really dangerous position.

Q8 **Diana Johnson:** You made a point about non-executive directors being able to look at information and take a view on safe staffing levels. Do you think that putting it into statute and showing the seriousness with which it is taken is to be welcomed, or is that not the view you take?

Sir Robert Francis: It is very important it is made clear to organisations and their leaders that this is important. Whether it needs legislation, as opposed to a requirement by NHS Improvement or something in the contract, I would not like to comment, but it is a question of the transparency of how they get their results and how they are measuring what they have provided by way of staff, as against the outcomes they are getting. I hasten to add that I do not regard an outcome measure to be adequate if all they are looking at are matters such as mortality. By definition, that is too late. They have to look more at the quality and safety of what is provided. Indeed, the improvement resource says they should be keeping a very careful eye on incidents and things of that nature, but it needs to be related to whether or not the staff are sufficient. Mid Staffordshire leaders, if they looked at them, certainly had hundreds, if not thousands, of incident reports in which staff shortages were said to be the cause and yet nothing was done in response. We need something that produces transparency in relating those two things.

Q9 **Maggie Throup:** Is there anything beyond workforce numbers that can be done to help nursing staff to deliver safe, patient-centred care?

Sir Robert Francis: A lot. I say in my statement that working conditions are one of the problems of the NHS workforce. I am not talking particularly about pay, although some would say that is part of it. If you look at the NHS survey—I quote figures in my report—the percentage,

which I would now have to look up, of staff who regularly work unpaid overtime may explain, or might explain, although I do not say it does, what seem to be alarmingly high figures in some parts of the NHS with regard to sickness absence. The number of people in the NHS who in answering the survey say they go to work even though they feel unable to do the work cannot be an appropriate figure. These are figures, it seems to me, that fall into that category where we should not be reassured simply by a reduction of a percentage or two over a period of a year, because if you translate the figure into numbers, it means 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 with 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.

I do find it incredible that despite the huge number of NHS statistics, it is not known why 25% of leavers left. I appreciate that people might be reticent about why they leave, but that seems to me an astonishingly large figure.

We need to give a message to NHS staff that we really value them and care for them. We can never make them rich, I suspect, but we can give them richer lives. Until we do that, we will have a staff which becomes increasingly demoralised and increasingly less capable of delivering what we, the patients, need.

Q10 **Maggie Throup:** In the statement that you kindly sent to us in advance of this hearing, you state that nurses are indispensable in any system of healthcare. You also talk about improving staff working conditions and mental and physical health, which is part of what you have just been talking about. From your experience of both reports you have done and the work you do now, there seems to be a big gap in pastoral care. Have you come across any good practice where pastoral care has been put in place, which we can all learn from?

Sir Robert Francis: It is one of those areas that gets squeezed every time someone thinks about what the NHS still likes to call cost improvement, which may improve cost but not much else. Professionals such as nurses—it works for doctors too—need time, particularly these days when they are not working with the same people all the time, to be able to reflect on what has happened and get support when things have not gone quite as they should have. They need the sort of pastoral support that they often don't get. Declaring an interest as a trustee of the Point of Care Foundation, one symbol of a caring organisation, but not the only one, is whether it is having Schwartz rounds, which are not just for nurses; by definition, they are for all the staff at a hospital. They can

get together and share a problem without the management being there with a clipboard asking for an action plan and so on. It is transformative. The more that sort of methodology is allowed time and space to develop, the better.

We still have to do something about what some people call a bullying culture, but I rather think of it as oppressive behaviour because I don't think all of it is intentional. It is about pressures and the blame that often goes backwards and forwards because of this. If people are behaving in a strange or unacceptable way, we don't just want to stop it in that individual; we need to think why these things are happening, and we don't see space or the resource being put into that sort of thing. Reflective practice needs to be encouraged and space given for it, and things that allow teams to sort out problems between themselves. It is no use having just a tick-box appraisal or review-type process. People need career development and time for a certain sort of training, even though someone in the finance department might find difficult immediately to understand how training of that sort will improve the bottom line. All these things are actually really important.

The working environment. A very simple thing is, how many times do I hear that the staff no longer have anywhere to have a cup of coffee or a rest? They are all required to eat, if they can find food, on the job. Why are staff not looked after in the way they used to be? It is not a question of the good old days; it is just that some of these things disappeared without anyone thinking what the impact on the staff is.

Q11 **Andrew Selous:** Do you have any thoughts on the proportion of time that nurses are able to spend in a patient-facing role? There was the time to care initiative a little while back. Is that part of the answer, or is that not going to yield that much for us in this area?

Sir Robert Francis: I think it is. I do not subscribe to the idea that we can free nurses from the responsibility of keeping records, because they are needed for clinical purposes as well as for all sorts of other reasons, but if you take that as an example, I find it strange that in 2017 so many places are still requiring everything to be written in handwriting that no one can read properly afterwards. Time is being spent with the same questions being asked of patients time and time again because there is no immediate electronic access to what they said last time. We urgently need—dare I say it?—digital solutions to make life easier for people at the front line so they spend less time filling in paper and more time dealing with patients.

I am sure there are other solutions as well, but that is certainly one of them. The nurses I talk to feel that they spend too long dealing with bureaucracy of one sort or another. Figures have to be kept and documents filled in and so on, but a lot could be done to ensure that they don't have to be repeated all the time. Observation charts are important; nurses and doctors look at them and make judgments about them, and medication charts and so on are filled in, but a lot of the manual work of

filling in things should be done automatically—but we need some capital investment for that.

Andrew Selous: That is very helpful. The Secretary of State did talk a little about this issue.

Sir Robert Francis: It is one of those areas where a great deal of genuine enthusiasm is expressed, and sometimes it is quite difficult to find a solution. We have had IT disasters before and we don't want to repeat them, but we must not give up that effort.

Q12 **Chair:** Following your reports, we have a new role, new routes into nursing to become a nursing associate. Do you have any views about what safeguards need to be in place both for patients and those working in these new roles and as healthcare assistants, so that they are not undertaking tasks beyond the roles for which they have been trained?

Sir Robert Francis: Obviously, it is very early days for some of these things. It would be wrong to be instinctively against roles that might increase the size and flexibility of the workforce, but it is very important for there to be absolute clarity, and a general understanding among those who need to understand, on what skills a person in these roles should be expected to have and what their job is.

What an existing support worker—they may be called caring assistants now—does varies hugely from one place to another. That may be all right for the individuals, but if you are looking at a grade of worker, you need to know what their training is, what they are expected to do and who is supervising them to do it. I say in my statement that when roles of this nature are looked at as a solution to a workforce problem, we have to bear it in mind that the registered nurse is likely to have to continue supervising such people. Therefore, we need to know what they need supervision for. I think there is now a move in this direction, which I welcome.

I believe there needs to be some regulation. Lawyers always talk about regulation, but what I mean by regulation is not necessarily the fully-fledged, GMC-type regulation, but standards of training and accreditation for that training. When I last looked into it, some healthcare support workers were let loose on wards after three or four hours' induction or training with no prior experience, and were expected to get on with it. That cannot be right if you are talking about someone called a nursing associate, but if it is a way of getting people into nursing I welcome it. We used to have somebody called a state enrolled nurse, who disappeared for reasons I cannot remember. Everyone knew what a state enrolled nurse did, what an RGN did and what a person who was not either—a nursing auxiliary—did, including, perhaps most importantly, the patient. I think it is very important that we don't disguise shortages in the workforce by having a lot of people dressed rather similarly walking round wards, with everyone thinking they are nurses when they are not. I would suggest we need clarity on all sides as to who these people are,

what they do, how they are trained, whom they are accountable to and how they will be supervised.

Q13 **Chair:** In your role with the Patients Association, is there anything on which you would like this Committee to be absolutely focused on behalf of patients?

Sir Robert Francis: Thank you very much for asking me to be here. I always have some diffidence in speaking for patients, but if that is what you are asking me to do, I would say that in deciding the supply and nature of the caring workforce in a ward there needs to be greater involvement from patients and the public who are affected, in a way that perhaps does not happen at the moment. We talked about improvement resources. I don't know what evidence there is that that has involved a discussion with patients and patient groups about its impact. When you are making changes to the workforce, or where there are issues with it, the first people you ought to ask about its impact are patients, so I would ask for that to be thought about.

Chair: Sir Robert, thank you very much for coming back to the Committee.

Examination of witnesses

Witnesses: Janet Davies, Sharon Allen, Daniel Mortimer and Jane Beach.

Chair: Good afternoon. We thank all of you very much for joining us. Will you introduce yourselves for those following from outside this room?

Janet Davies: I am Janet Davies, Chief Executive of the Royal College of Nursing.

Jane Beach: I am Jane Beach, Lead Professional Officer for Regulation with Unite.

Sharon Allen: I am Sharon Allen, Chief Executive Officer of Skills for Care.

Daniel Mortimer: I am Danny Mortimer, Chief Executive of NHS Employers.

Q14 **Chair:** Perhaps I may start with Janet Davies. Will you tell the Committee, in your view, what the current problems are with nurse staffing levels and what impact they are having on patient care?

Janet Davies: If we are looking at staffing levels, a number of things are troubling nursing. We are in a very challenged place at the moment—probably more than I have ever known. The problem with staffing levels at the moment is that we clearly do not have enough nurses in the health system, not just in the NHS; when we look at staffing levels, our nurses are trained to work in all sectors, so that includes nursing homes, domiciliary care and the independent sector.

From the work that we have been doing with nurses, we found that over 50% of the 30,000 nurses who spoke to us said that on their last shift they were seriously understaffed. That means that care is left undone. It means that patients are not getting the care that they require. Obviously, it also has an effect on patient safety. It is in all sectors: in hospital, and in community—people waiting for a visit that is late or covered by someone else. Mental health and learning disability in particular have some serious problems, so across the board nurses are saying that it is difficult to provide safe care because of the levels that they are working with. That was the view of over 50% of the 30,000 who spoke to us.

Q15 **Chair:** Are there variations in terms of geography?

Janet Davies: There is difference in terms of geography. There are particular problems in London where there is higher turnover, but it applies generally across the whole of the UK. There is not an area where they can say that they have lots of staff. I think one trust has a 3.5% vacancy rate, but it can be as much as 15% or 20% in some areas, so it is a problem for all areas at the moment.

Sharon Allen: As Janet says, we have nurses working in social care, primarily in the residential nursing care sector, and the real issue that employers are telling us they are facing is retention. You can see from our submission on retention or turnover rates that employers need to replace approximately one third of their nursing workforce each year. We have seen the number of nurses working in social care reduce by 8,000 over the past five years—4,000 in the past year alone. Some providers are struggling so much to get nurses, and keep nurses working in social care, that they are re-registering and stopping providing nursing care, which obviously impacts on what is available locally and on what is happening in terms of health, with people not being able to come out of hospital.

I think the key issue in the problem being so acute in the social care sector is the image, profile and status of social care. What we need is parity of esteem for people working in social care, for nurses working in social care—for the whole of the social care workforce to be recognised. Sir Robert Francis was talking about valuing the workforce. We need to see this for social care, rather than it being seen, unfortunately, as the junior partner or, even worse, a Cinderella.

Q16 **Chair:** You touched on one of the points that was going to be in my next question. We are going to be talking later in this session about workforce planning for the future. What strategies do you think need to be put in place here and now to try and relieve these pressures?

Daniel Mortimer: The biggest area of concern, which all the organisations represented here are working on together, particularly through the Cavendish Coalition across health and social care, is that, while there are plans to increase the availability of trained nurses and

develop new roles and entry routes into nursing, there are significant lead times for all of those plans and policies.

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 Janet has 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. As a country and as a bunch of employers and trade unions, we are signed up to the relevant World Health Organisation guidance on ethical recruitment; we comply with that in the UK, but that is a serious and urgent response to the gap that I am sure has been described in all our submissions to you.

Jane Beach: There are particular challenges within health visiting and mental health. Since health visiting transferred to commissioning under the local authority, we are seeing services reconfigure and redesign and a reduction in the number of health visitor posts. Staff are being downbanded. They are still working within the service but not as a health visitor, which, as you can imagine, for any professional is incredibly difficult. They are being put at risk professionally because they are working outside scope. Coming from a health visiting background, I have never experienced what we are experiencing now. Our members are voting with their feet and leaving. Even those who have not been in the profession long, who came in under the health visitor implementation plan, are going back into other roles within nursing or leaving nursing altogether, because they cannot do the job they were trained to do and their specialism is not being recognised. We have seen a 13% drop in the number of mental health nurses. Stress at work and caseload is the biggest factor, even over and above pay, which obviously is an issue too.

Q17 **Chair:** We are going to come to future workforce planning, but before we do so, may I ask each of you to set out for this inquiry the impact on patients?

Jane Beach: There are a couple of issues. Caseloads within health visiting and mental health are going up. Staff are reporting that they are having difficulty delivering even the core mandated contacts under the health visiting service. Health visitors are key professionals in assessment. Some of the key visits are not now done by a health visitor, so inevitably that will impact on clients, patients, children and their families, and the same in mental health.

Janet Davies: What patients are telling us and what we have reported—I would not want to speak for patients as a group—is that quite often it is the small things that are really important that are missing, either because the same person is not consistently visiting them at home because of a shortage or there are not enough people in the clinical area where they are being cared for, which leaves some of the fundamental things that are important to their wellbeing that are not done. Our nurses say the

same. They go home really tearful and upset because they have not been able to provide the care that they want. Quite often, what might be seen as the added extra that a nurse would provide—sitting with someone, talking to them, holding their hand and reassuring them—is probably one of the things that keeps people the safest. That is when you see the condition of that person, what you might have to do and how you may react to it. It is also important that we have enough information that we then pass on to our colleagues, so that everybody knows what needs to be done and what that person's needs are.

It is also about people's hygiene needs, for instance. One of the complaints we hear is that someone has not had a shower for two, three or four days. It does not mean they are unsafe, but that is a very unpleasant situation to be in and it will not help recovery. It might not immediately threaten your life, but it can threaten your recovery and fundamentally change your survival. Things that happen when a qualified registered nurse is caring for someone in the shower are far more than just cleaning someone; it is looking at their skin and all the observational things when someone is undressed. You can check their wounds; you can do all these things. Sometimes, with nursing, the job is split up into what you see and those tasks rather than the knowledge that is being displayed while you do those things. Those are the things that get missed, which end up being quite dangerous. If you are at home and totally dependent on a district nurse or community mental health nurse coming to visit you to keep you safe and keep you well and that doesn't happen, we see people in a crisis situation, which is far worse, coming into A&E in a situation that should not have happened. That is what happens when you do not have those qualified nurses, who know their patients, caring for them.

Sharon Allen: I echo what has been said. The point to add about social care is that this is about people not being able to live safely in communities if we cannot provide the appropriate level of nursing care in those communities. It also impacts on the wider workforce and the ability of care and support workers. Nurses are quite small numerically in terms of the whole social care workforce but have a massive impact on the whole-team approach to enabling people to live fulfilled lives, which is the purpose of social care.

Daniel Mortimer: Clearly, what Sir Robert did with his second report was force the NHS in particular to completely reset its thresholds about what good care looked like. Janet set out the totality of that far more eloquently than I could. That has meant we have had to recruit and employ a lot more nurses over a very short period of time. It means we have probably recruited a lot of staff from Sharon's members because we pay more in the NHS than social care does, as I am sure Janet will go on to explain. That is still a concern for her members.

Even within that, we see some real areas of pressure that are causing the kinds of problems that Janet described but also leading to delays. The

two areas that we worry about most in the NHS are: capacity in the community, including social care, and mental health services. As Jane described, we have seen quite a dramatic reduction in the availability of trained nurses in mental health settings. In the acute setting we have seen a very dramatic growth in those numbers. We would not pretend that is enough; we are still carrying significant vacancies, but there is a risk that those two areas outside acute hospitals get lost as particular areas of concern.

Patients, clients and service users in those settings are experiencing delays, are experiencing care below the standard that nurses themselves would want to provide. Our concern and the concern that NHS Providers has articulated today is that we have relied on an enormous reservoir of good will and extra work by our staff, often unpaid, as Sir Robert said. That has to have a limit; we cannot survive on that going forward; we have to be able to recruit the people in that numbers we need and deploy them to provide the kind of care Janet described.

Chair: May we turn now to workforce planning?

Q18 **Luciana Berger:** In a previous session of this Select Committee we heard from the Lords, who believed—we have heard it more broadly—that the current nursing shortfall is a result of poor workforce planning in the past. Are you confident that national bodies have now made realistic projections of how many nurses will be needed over the coming years?

Janet Davies: I would say not. Over many years people have commissioned the number of nursing places that they believe they can afford rather than what they need, so it has come very much from organisations to deal with whoever over the years. There is always some arm's length body of one type or another—they get reorganised and come back in a different form—deciding how many nurses they think they will need in three years' time. It is usually hospital-based and does not take into account the whole picture. The usual approach is, "We're not going to have any more money, so this is how many we are going to be able to employ." We have an ageing population; we have increased acuity in our hospitals; we have increased acuity in our domiciliary care; we have nursing homes that are never taken into account; and we have a whole independent sector, including occupational health. We have a nurse on building sites; we have a nurse everywhere, caring for people, as well as some of the preventive work.

There has never been a fundamental look at, "What does this population need in terms of the number of nurses?" It has always been based on demand and employment, and it has just proved to be flawed over the years. It has never been right. When the RCN had its centenary last year and we looked through all our own minutes, we found that this has been an ongoing issue since nursing was first regulated. It has to look at population health; and the way we stagger from too many to too few has to be looked at in a very different way. I don't think we feel that that has ever been done or is being done now.

Daniel Mortimer: I think there is a change now. I respectfully disagree with Janet. I recognise the history, and in our submission we describe the mistakes, very much along the lines Sir Robert did, in the way in which workforce planning assumptions were driven over many years. When we see the data from the summation of the STP process, for example, we see people predicting a growth in the nursing workforce. It may well be that that is not sufficient and more work needs to be done through the STPs, but that is very different from what Sir Robert said the FT process drove. We are understanding much more the relationship between what happens for Sharon's members and my members. It is not just about the workforce within the NHS; it is about the workforce within a whole place, and there are examples where people are trying to help each other in joint work, particularly around the nursing workforce and the support workforce. There is a long way to go; I am not pretending that we have addressed all the problems that we have identified here, but I do think that we are in a better and more realistic place.

The compounding factor is that the level of investment, especially in social care but also in core NHS services, is not keeping pace with the predictions that we are now making around the workforce that we need. As Sir Robert touched on in his evidence, there is a risk that we return to money absolutely limiting our ability to invest in our nursing workforce. I think we already are in that place in social care in many, if not most, parts of the country.

Sharon Allen: Thank you, because you have articulated it very well for me. I agree with Janet that the need for nurses working in social care has not been factored into projections and thinking about workforce planning. We need to think about the workforce we need locally with the whole skill mix, because we cannot look at just one part of it in isolation. Social care needs to be a key part of that. If we are trying to think about different ways of doing things, we cannot keep modelling for what we have done in the past and what we want to do in the future. For example, if we are not thinking about how nurses could support domiciliary care providers, skill up the workforce and provide different levels of supervision—if we are not thinking about those different models—we are not going to plan to have sufficiency.

Q19 **Luciana Berger:** We know that Health Education England has a five-year rolling programme of assessing workforce needs. Will you individually share with us, on behalf of your organisations, to what extent Health Education England has engaged with you as a stakeholder in that process, and whether you believe that process has been done well?

Jane Beach: We would probably say not. We have not really had that much engagement. The fragmentation in the system and data collection make things difficult. Nurses now working in local authorities don't go on to NHS Digital, and nor do nurses in lots of other settings; so it is really difficult to get accurate numbers of nurses in different settings. There is

also a time lag. You can get figures, but there is always a six-month time lag, so that makes it very difficult.

Sharon Allen: We do have good data about nurses working in social care. We collect something called the national minimum data set for social care. The number of nurses working in local authorities is pretty small because, as you will be aware, most social care provision is in the independent sector. The challenge is that that is primarily the small business sector, so trying to align planning processes for a national, centralised, albeit delivered locally, service in a very fragmented sector is quite difficult.

Q20 **Luciana Berger:** Have you had direct engagement with Health Education England in this process over previous years?

Sharon Allen: We do work with Health Education England. We have not had direct input into workforce planning. We work with local authorities and local providers on their workforce planning. The point is that it needs to be better joined up.

Janet Davies: We have had direct engagement, but it is really difficult for Health Education England, because there is not a full picture of nurses and where they work. We, along with the regulator, probably have the best picture, but one of the difficulties is that the number of nurses does not sit on the database that is then used, particularly in mental health where provision is not by the NHS. It might be NHS care, but it is being provided by the third sector, the independent sector and increasingly there is more provision by other sectors than the public sector. Those figures are not readily accessible, so they fall out of the system of workforce planning.

We have a very complex environment now. To give them their due, it is an almost impossible job to predict how many nurses you will need for a whole population. While progress has been made in STPs, there are whole areas where that data is really hard to get. We need to look at the population itself and how sick it will be, regardless of where nursing is provided, when we ask how many nurses we are likely to have for the population. We tend to get stuck in the current infrastructure of the NHS and others, which might be very different in five, 10 or 15 years. We will need different models and it will look very different, but we are still tied to the old-fashioned model, which I do not think has ever worked. There probably needs to be a radical rethink of how we determine it, even if it is just by head of population. It probably has to be more scientific than what we have at the moment.

Daniel Mortimer: In its relatively short history—HEE has been around for only four or five years—it has not been given the investment to put in place the local infrastructure that would be able to compensate for some of these issues, so that we could have a meaningful engagement with social care in a locality, or even a sufficiently meaningful engagement with the NHS. I think efforts are made in that regard. My members report

engagement, but there is insufficient capacity for HEE to fill the gaps and work alongside particularly Skills for Care, so that there is a joined-up picture. I know that is a frustration for HEE colleagues. They did try to put in place that structure when they were first set up, but we have not had sufficient investment in that. The investment has been taken from HEE in effect and put into frontline services through NHS England, which the Committee has reflected on previously. There is much more we could do, but it would need significant investment.

Q21 **Luciana Berger:** One of the key factors that will determine how many nurses we need is demand for NHS services. You may have seen the report out today from the Nuffield Trust that has calculated that, if British pensioners under the S1 scheme have access to the NHS and require its services, the additional resources needed would equate to 1,000 extra beds and £500 million of extra funding. Will you share with the Committee your reflections on the impact of that and how many more nurses we might need in the NHS as a result of that?

Janet Davies: It is hard to say how many, for the reasons I have given. Again, it is across all sectors; it would not all be NHS, but that is the problem of not having any safe staffing legislation for sectors, as we heard from Sir Robert, as well as not having a really good system of knowing how many nurses you will need if that is your population and that is how sick people are. We do not have that level of knowledge at the moment. That is a really good question, because that is exactly what we should be able to answer. Nobody can do that because so far it has been based on providers.

Daniel Mortimer: The Nuffield is a large hospital—1,000 beds. It is a large teaching hospital-type provision. The one I left three years ago had 1,500 beds and employed 3,500 trained nurses, so, crudely, if they are talking about acute beds, that means 2,000 to 3,000 more trained nurses. It is a big increase in the demand that we would need to meet if it came to pass.

Sharon Allen: It does not mean that everybody will need hospital care. We have to think about the models we want for our communities. We know that ideally most people want to be cared for in their own home, if possible, or somewhere small and local to them. We need to look at all the things that have been talked about, as well as the models of care and the skill mix within local communities.

Janet Davies: There are mental health needs as well; it is more than just physical health, so it is complicated.

Q22 **Chair:** Janet, you said that the current systems for recording where nurses are and what they do are inadequate. Do you have a clearly developed idea about how that should change and what it would look like?

Janet Davies: For at least the provision of NHS services, which is easier to look at, I think it should be compulsory for the staffing levels and the workforce data to be held within NHS Digital. Although they are not provided by the public sector, they should be seen as a whole, so we can see the whole picture. It does cause difficulties. Recently, everybody has been looking generally at the number of mental health nurses we have lost, which we have, but some of those nurses are continuing to work as mental health nurses and providing NHS care, but because they are providing it in a different sector it is very hard to get that data together. That is really important.

Chair: It should be compulsory.

Janet Davies: Yes.

Chair: Do the rest of the panel agree?

Daniel Mortimer: Yes. It is relatively straightforward for the statutory NHS because we all use the same payroll system. The most effective way of collecting workforce data is making sure you pay people. We have that, but there is not the same ease of access to the data. In fairness to colleagues in the independent sector, as with colleagues in the social care sector, I think people do work to pull together the data sets. It is not even mandatory in the NHS; it is just there, because a million staff are paid through one system, as it were.

What I see as a deficiency is that local conversation about what is needed—this needs to be built from the ground up—and the capacity to be able to engage people within particular places, to use the current vogue terminology. That is the bit where we could have a meaningful analysis of what people have got and what it is they believe they would need.

Q23 **Chair:** It is a matter of having the capacity to analyse data meaningfully and to do that at local level as well as national, across all the different sectors. Would that be fair?

Daniel Mortimer: Yes.

Jane Beach: I would definitely agree with Janet. The other thing that we need to be mindful of is that when collecting data it is not always recorded which nurses have hands-on or clinical responsibility. In particular, within health visiting you can count the number of health visitors who have a health visitor qualification, but that does not necessarily mean they are working with patients. I would make it mandatory to draw a distinction between those two so that the figures are more accurate.

Sharon Allen: The data set we have in adult social care is the national minimum data set, with the emphasis on minimum. The count principle—count once, use numerous times—is not a mandatory collection. About 60% of CQC-regulated providers provide their data, which means we

have data on over 750,000 individual workers and 20,000 establishments. That gives us very robust data, which was used by the Department of Health and many other organisations to help with analysis and planning.

Q24 **Dr Caroline Johnson:** Jane, just recently you made a point about the number of hands-on nurses, but when others talk about safe staffing levels most often they are referring to how many nurses you have on a ward in relation to how many patients there are, how dependent they are, how unwell they are and how often they need a nursing intervention.

One of the things that has changed quite significantly over my career in the health service has been the roles that nurses take on. We are talking today about the number of nurses and whether we have enough of them, but we also know there are issues with doctors and vacancies in medical staff. In order to fill vacancies, successive Governments have utilised the skills of nurses to fill those gaps. I am thinking of the increase in the number of nurse practitioner roles in various departments. Nurses have also taken on roles in training and the development of patient safety, patient care and teaching.

In my experience, that has been done by the more senior nurses on the ward. To what extent do you think that has impacted on workforce planning? We have nurses, but they are not doing the hands-on role and contributing to staffing numbers. I can see that it offers a career pathway for nurses and may retain them, but is it retaining them always doing what we need them to be doing, or is it just helping to make the doctor numbers not look quite so low?

Daniel Mortimer: I think it is what we need them to be doing. We need nurses to be chief executives; we need nurses to be doing advanced practice and carrying out research.

Q25 **Dr Caroline Johnson:** I am not suggesting that we don't. There has just been a massive increase.

Daniel Mortimer: But if I may, that was the language you used. We absolutely need people providing the kind of services that we have talked about in our communities and in our institutions, but we need nurses leading those institutions; we need more nurses doing research.

Q26 **Dr Caroline Johnson:** I am not suggesting otherwise. We are talking today purely about workforce numbers. As a proportion of the nursing workforce, do people in those roles make up a higher numerical amount of the nursing workforce than they perhaps did 15 or 20 years ago, and is that something that was not predicted as part of workforce planning? And is it something we are looking at going forward?

Janet Davies: I can come in on that. There are a number of things there. One is about what is an advanced nurse practitioner. That is a nurse at the top of their clinical licence, being able to operate to the level that they possibly can. I wouldn't say they are covering for doctors. In my experience, they are meeting patient need quite often that was not

being met and they may be taking on some of those roles that had been undertaken by doctors. I see that as a natural progression within a career in any profession, and I think it is natural for nursing. We have nurse consultants who—

Dr Caroline Johnson: I understand that. The question is about numbers—what impact you think it is having on the number of nurses.

Daniel Mortimer: It has grown.

Janet Davies: It has grown because they are there to meet patient need. As patients are living with more complex needs, living with conditions they may never have met before, the majority of nurse practitioners are working in very specialist areas—they are working in the community, they are working with hard-to-reach areas, with the homeless and with people for whom there were no services before.

Dr Caroline Johnson: I get all of that, but I am asking what effect you think it has had on numbers and what effect you think it has had on the proportion of the workforce—

Janet Davies: I think it is a very small number, in fact. It is those people that are able to do that. It is a very, very small number.

Dr Caroline Johnson: Does anybody have any figures on that?

Daniel Mortimer: No, but we are very happy to provide them to you if we can.

Janet Davies: That is, if we have got them, because we can only do nurses by grade. We can certainly look at the ones that we credential as advanced practitioners, but I think that one of the things that will keep nurses in the profession and not lead them to leave is if they can see a clinical future for themselves. If it stops at ward sister level and your only choice is to become a manager, we do lose people—we will lose people to other professions. We heard from Sir Robert Francis that that continuing professional development and that ability to keep up to date but also to progress, is really important. Of course, if we want really good-quality nurses, we need nurses who are able to be lecturers, to work at universities to teach the nurses of the future, as in any other profession. It is a question sometimes that is asked about nursing that we do not hear in other professions because people's vision of nursing is the start of your profession, when you are working maybe in a hospital ward. It is very important that we have a good number. We do not have enough advanced practitioners, so when we are looking at the primary care work and the work we have been doing with the Royal College of GPs, that role that nurses can take on—

Q27 **Dr Caroline Johnson:** The question is: does that mean that you predicted in the past you would need a certain number of nurses without predicting that a number of them were going to—

Janet Davies: That might be one of the elements, yes.

Q28 **Dr Caroline Johnson:** I know from my own experience, working in a

number of hospitals around the country, that there are definitely more nurses taking on those roles than there were at the start of my career. I am asking what effect it has on the numbers.

Daniel Mortimer: I think you are right, and to link your question with Ms Berger's question, I do think that, over the years, we failed to properly anticipate the growth in the advanced practice workforce in particular; and we failed to understand particularly the growth we have seen around the cancer pathways, where we have seen probably one of the biggest growths in the specialists. We failed to properly understand the response that we had to make to doctors complying with the European working time directive in some institutions. Again, I think we are in a slightly better place now about understanding the extent and depth of the contribution that advanced practice can make in nursing and other professions, but we are still catching up. You are right that we had not properly anticipated that kind of growth in demand from nurses operating in extended and advanced roles.

Q29 **Dr Caroline Johnson:** Do you have the figures, or could you write to us?

Daniel Mortimer: Not immediately to hand, but we can get those for you.

Jane Beach: It would be interesting, because certainly my experience in the community is that we used to have public health nurse consultants and I am not aware that there are any.

Janet Davies: They are reducing, yes.

Jane Beach: They are reducing that level, but as people have said, it is a really important element of keeping staff. You must have somewhere to progress to.

Sharon Allen: In social care you will find that quite a lot of owners of small provider organisations are nurses who are using their skills and their practice leadership role to set up something, where they are confident they can provide high-quality care, which also needs to be factored in to these considerations.

Q30 **Dr Cameron:** It is extremely important that we have nurses in highly specialist roles in which they teach and lead services, but in terms of career progression, if the number of posts is dwindling what proportion of nurses are we losing to managerial roles where they might not have patient contact?

Janet Davies: We have always had nurses in managerial roles from the days of the matron. It is very important that we have clinical leaders within the NHS and beyond in healthcare. My biggest worry is those we are losing before they get to that stage. We certainly know that for the first time we have more people leaving the nursing register than are joining it, which, considering this is not too long after the Francis report, seems to be going the wrong way.

The NMC did the work—I presume you will be taking evidence from them, so they will be able to give you more detail—and found that the people

who are leaving are very experienced but are not necessarily in the specialist roles. They are leaving because of the pressure of work and the inability to progress, as well as pay, but the No. 1 reason is the whole vicious circle of working under so much pressure because of lack of staff. Actually, we have a real danger at the moment because, sadly, since Mid Staffs, we have had a reduction in investment in nursing education. Not only have we seen the budget for training our nurses removed, but we have also seen a huge reduction in the amount of funding for continuing professional development. That is not only the nurses doing a programme to keep up to date. This is the training for district nursing, for health visiting and certainly the advanced practice and the specialist nurses. I can see that it is going to be very difficult to do that.

To give some context, I have the figures on that. Two years ago, the budget for continuing professional development for nurses in England was £205 million. This year it is £83 million. This is at a time when we are trying to develop nurses—bring more roles in. That is creating so many problems. It is causing problems with providers. This is not the nurses who are not in the system. 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. Of course, there is no money for those programmes at the moment. It has been pretty much decimated.

What we might see by default is a reduction in those specialist nurses and those advanced practitioners unless we can find a different way of doing that. We are looking at options, and one thing we are doing is looking at how we might use the apprenticeship levy in a different way and other sorts of funding. I find it pretty sad that, when we are so desperate for nurses, we are taking out the funding for them to continue to develop.

Q31 **Dr Cameron:** It is absolutely crucial that nurses feel valued and able to develop and have that investment in their profession. The matron had hands-on patient contact, but I was asking what proportion of nurses are moving into management roles where they do not have direct patient contact.

Janet Davies: We do not have those figures and I do not know. Danny might know more about that. Most have some direct patient contact even at director of nursing level, if not working full shifts, but I don't know.

Daniel Mortimer: I also don't know. Again—and perhaps as with Dr Johnson earlier—I might be misunderstanding what lies behind your question. We want services that are led by clinicians. The Secretary of State has a particular interest in doctors taking on a more pronounced leadership role, and I think that is right, but we need nurses, allied health professionals and others to be leading our services. There is enormous value in that.

Q32 **Dr Cameron:** I am not saying that I do not think it is of value—I think it is of extreme value and it is the way that we should be going—but it is

also important that people in those roles continue to have contact with patients and understand what is happening on the front line and understand how nurses operate.

Daniel Mortimer: I am not a nurse or a clinician. I worked in frontline health organisations for 20-odd years. I had contact with frontline patient services and my board colleagues had contact with frontline patient services. We went about that in a much more systematic way following Sir Robert's report. What I see from the experience I have of colleagues at board and managerial level, whether they are a registered clinician like Janet or not a clinician like me, is that they take that very seriously as part of their work. I clearly was not providing hands-on care; a chief executive of a trust who is a nurse does not provide hands-on care, but I had regular contact with patients and with the teams that were providing services. It was an important part of my job.

Q33 **Dr Cameron:** Do you think that should be built into CPD—that continued understanding of the frontline, being able to know what is happening?

Daniel Mortimer: Sir Robert touched on it. It is a really important way of working now, particularly for boards in the English NHS. The process of patient safety conversations—of patient stories, of boards, and the more direct engagement with families, particularly if they are raising concerns—is much more pronounced since Robert's work. I think it is a really important part of how all members of a board or a leadership of a healthcare organisation would work. Within the English NHS I think we have made big strides in that regard, as I said, particularly since Robert's second report.

I echo the point that Janet made about continuing professional development—the disinvestment that we have seen. The transfer of money from, in effect, our training budget to service delivery is, I think, the biggest single factor now in poor rates of retention within the NHS. We share that concern with the RCN.

Q34 **Dr Cameron:** Health Education England anticipates that 87,000 non-retiring nurses will leave the NHS between 2016 and 2021, resulting in the NHS requiring 84,000 joiners over and above newly qualified staff, which gives us a sense of the scale of the challenge. It is a huge issue. What do we know about why nurses are leaving the NHS?

Daniel Mortimer: We have run a programme over the last 12 months with 92 NHS provider organisations, and our colleagues at NHS Improvement are running a programme at the moment with a further 30, and the 30 that they are working with are the ones that have the highest rates of leavers. Those are people who leave an NHS organisation and don't reappear within the NHS—because we have the data set that we talked about earlier—within 12 months. We always see people moving between NHS organisations, but these are people who leave the NHS and don't appear anywhere else on our books.

We have seen lots of things, but there are three areas that seem particularly important in the work that we have done with the 92.

The first is how new staff are looked after. While we have the concept of preceptorship for newly qualified nurses, those organisations that go above the minimum—perhaps run the preceptorship programme for longer and have much more dedicated support for newly qualified nurses—seem to have a much better chance of keeping those nurses. We know that the longer we keep people—if we can keep people past the first few years they are much more likely to stay with us.

There is a second theme, which seems very strong, which is about enabling career development for our nurses and making it much easier for people to make choices about how they can develop their careers within our organisations. In simple terms, when we advertise a job, we treat applications from people within our institutions exactly the same as those from people outside our institutions. We don't make it as easy as possible for people to develop their career within the NHS.

The third thing is that there is some really good work and we are starting to see some improvements in the number of people who retire and access their NHS pension but then come back into practice. That is particularly important in mental health, where a large number of colleagues have special status in terms of being able to access their pension earlier.

Those three things do seem to make a difference. I would also echo Janet's point: we see and hear very clearly from our nursing colleagues that the pressure they feel in terms of the demand for our services—the longer waiting times that patients are experiencing, the difficulties in transferring care and the greater dependency, or more unpredictable dependency, of an older population with more complex needs—is also taking its toll. So while there are things we can and must do in terms of the quality of the employment offer we make to people, there is also a factor to do with the investment in our services—in our capacity—and to do with the investment in community and social care capacity. Our nurses in acute and mental health settings feel that pressure more acutely probably than any other part of the workforce because they are the people dealing with patients and their families day in, day out and struggling to properly meet their needs, recognising that there might be better places for someone to be cared for or dealing with the consequences of delays in treatment. Janet touched on those things, which are clearly having a profound impact on how people feel about working in our services as well.

Jane Beach: Certainly, what we are seeing and what our members are reporting to us is that they are really struggling financially—community staff in particular, because there has been so much movement and services have joined together, so you might get a health visiting service in one area provided by a provider that is in a completely different area. Therefore, they are travelling a long way to access management support, but the areas they are covering have also grown, and this goes for mental health in the community as well. Even with things such as their mileage rates—once they do over a certain number of miles they get paid

less and there is also a delay in payment. We have members coming to us for special payments because they really can't make ends meet. They are spending a lot to work, so they are subsidising their work.

You put that on top of the fact that there are fewer health visitor posts—health visitor posts are being removed and they are being downbanded—so there is nowhere for staff to aspire to. Health visitors who have been downbanded feel totally demoralised. If they are coming up to retirement age, they take the option of retiring or they leave. In the past, a lot of staff would retire but might come back, but now they don't. They are retiring and coming off the register altogether.

Janet Davies: There is something to be said about the recognition of the value of the staff, particularly in nursing. There is still in some areas a lack of flexibility—that is, enabling people to feel valued when they are at work and not requiring them to work so much that they only want to work one or two days a week because they are so exhausted at the end of the day.

Some of the things that have happened over the years in the guise of productivity have caused some problems. One issue is absolutely no handovers between shifts, which does not make sense at all, but on paper, to an economist, might look quite good because you are not double-staffing at any point. It means you have to stay, unpaid, to hand over the care of your patients, which, as it becomes more complex, takes even longer, or if you are hurrying to get off, that is a real patient safety issue. We heard about the Schwartz rounds from Robert Francis—fantastic things, but how on earth can a nurse leave the patient to go to a Schwartz round, particularly if there is no built-in time for education, for continuing development or sometimes just to go and have a cup of tea?

One thing that shocked us last summer when it was really hot was that in some areas we had to put out a message to say, "Make sure you get access to water when it is really hot." There are some areas where there still is not drinking water for nurses. The very high workload in communities means you have to write up all your patient notes. Quite often you have electronic equipment for which you cannot get a signal, so you have to go back to the base and write everything up at the end of it. These extra hours coming from what on paper looks like more efficiency create an awful lot of problems. Danny talked about good will, with nurses staying late to finish things off, partly because there are not enough staff and partly because there is no handover time. Food and drink must be provided in a place where you can get it without taking up half your break to do so. If you have a 15-minute break and it takes 10 minutes to walk there, it is very difficult.

Daniel Mortimer: If I may say so, Janet, probably the majority of institutions have not removed handover. I have not worked anywhere in 25 years where we have removed handover completely. You may have examples where nurses feel they do not have sufficient time and—

Janet Davies: It is particularly with two 12-hour back-to-backs.

Daniel Mortimer: I am not disagreeing with that, but I would not want there to be the suggestion that, for productivity reasons, the NHS has stripped out handover as a matter of routine across its services, because I am not aware that that is the case. I am not doubting that people have raised concerns with you.

Our staff survey tells us—Robert touched on some of the problems that are rightly raised through the staff survey that we have to tackle—that people are still prepared to recommend the care they provide and are reporting lower levels of stress, though still at too high a level. There are things that people are doing that are improving situations, but it is too slow and the demand that is being placed on people is such that in some ways they are running to stand still relative to the demand that is being placed on our services. I apologise for cutting in.

Q35 **Chair:** This is an important point. Is it possible for you to write to us to give us a flavour of how serious this problem is of lack of handovers?

Janet Davies: Absolutely, yes.

Chair: While it is a relief to hear it is not a national issue, if it is happening in a significant number of places, or there is evidence that it is growing, that would be of interest to the Committee.

Janet Davies: Of course we can. Nothing is the same everywhere and there is good practice, but where we have those two 12-hour shifts it is a real problem, because there are 24 hours in a day. That is an area that concerns us greatly, particularly with patient safety and the number of hours people are working. Of course, nothing is the same everywhere.

Sharon Allen: May I add something on nurses leaving social care? Some of them, despite everything you have just heard, are leaving to go to work in the NHS, because whenever there is a challenge locally in the acute sector things happen that attract nurses to go and work there. We cannot ignore the lack of parity in terms and conditions—not necessarily pay, although that is a perception, but the whole package of rewards, including pensions and, importantly, investment in continuing professional development. However much is being stripped out of what is in health budgets, social care employers in the sector look with envy because we just do not have that level of investment. Again, there is a need for greater joining up of how we support colleagues. The Schwartz rounds are a good example. How could the manager of the local nursing care home join initiatives to give that sense of join-up and give some peer support? One of the most significant things for nurses working in social care is that they are not part of a team in the same way, so they are often the only nurse on duty in a small setting.

Q36 **Dr Cameron:** You painted a picture of appalling working conditions contributing to people leaving a career that they presumably are very dedicated to.

Janet Davies: In some places, it is partly because of the lack of staff. It is a vicious circle: we need more staff, we need people to stay, but

because we are so short-staffed it is harder to get people to stay. At the same time, one thing I need to be clear about is that nursing is still a fabulous profession and people still want to be nurses and people love being nurses. They get very distressed when they cannot do the job how they want to do it. Many of them really don't want to leave nursing. Every day I see an example of fantastic nursing practice, and there are some really good areas. I talked about our survey. Over 50% were feeling very short-staffed. It does mean that of those people that answered, 40% had a good experience and a good shift. The difference that that makes is quite phenomenal. Reading what people tell you about their shift when it has been well staffed is a good example of what good nursing is: they talk about the wellbeing of their clients or patients, their improvement and recovery, and how they feel about that, rather than how they feel. They go home feeling that they have done their job. So I would hate to—

Q37 **Dr Cameron:** Nurses want to be good nurses and to do a good job.

Janet Davies: That is exactly what they want to do.

Dr Cameron: If they are left feeling demoralised because of working conditions—

Janet Davies: That is what we are hearing, and those are the things that we are very concerned about, and where we really need to see some significant investment in the solutions.

Dr Cameron: So what can employers do, and what should be done at the national level, because this is very serious?

Daniel Mortimer: As Janet acknowledged, we are a massive employer—the biggest in the country—with several hundred different institutions in every locality in England. We see unacceptable variation. I am not excusing it, but we see variation between the very best and we sometimes see variation within institutions as well in terms of the problems.

Q38 **Dr Cameron:** Do you monitor that variation to find out where there are issues?

Daniel Mortimer: Yes. The CQC in particular looks at the experience of staff. The staff survey highlights that. We are targeting work on organisations that are experiencing the highest rates of leavers, so yes, there are actions that are there. That dynamic around staff experience and whether there is proper leadership and support for staff is a fundamental part of the CQC inspection process that, again, Sir Robert's work has triggered and that he continues to oversee as a non-executive. Yes, it is there.

I have touched on some of the factors where we are encouraging employers. We see employers using "Make a Difference" in keeping people and making them more fulfilled. We still see in the NHS, despite all the pressures and challenges that are on it, that the level of staff engagement—the academic measure, if you like, in how people feel about their work and their organisations—continues to improve. We would still

like it to be better, but it has improved every year for the last 10 years, in spite of all the pressures we have highlighted here.

On national action, some things have happened. There are clearly some high-cost areas within England—particularly here in London—and the recent announcement about improved access to affordable accommodation for NHS staff is welcome. We believe that here in London and parts of the south-east it will make a big difference in being able to keep people in this locality and to stop that drift out of London that the RCN and ourselves have been reporting for some time.

We believe that the CPD budget is the next fundamental thing on which there needs to be national action. The level of disinvestment that Janet has described limits the opportunities for people—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 and so on—and has a symbolic value. There may be lots of nursing colleagues who, for whatever reason, do not want to access CPD, but we would like to think that they could do so if they needed to one day. The level of reduction that Janet has described is making a big difference in the psychological contract that we have with our workforce.

Q39 **Dr Cameron:** Is not CPD mandatory?

Daniel Mortimer: There is absolutely a level of continuing professional development that is mandatory for revalidation so that nurses can remain on the register but, confusingly, the postgraduate training budget—the budget we use to invest in further training for nurses once they have received their diploma or degree—is also called CPD. That is the budget that Janet has described as having more than halved in the last four years. That is a national budget.

Q40 **Dr Cameron:** From what has been said, it is not just about money in CPD. Nurses need time to be able to go on the CPD, because how do they do that in addition to everything else?

Daniel Mortimer: Janet will have intelligence on this, but where employers prioritise people needing to pursue a training course or university course to develop their practice, time is made available for them. Again, I am sure there are examples where that does not happen, but people will prioritise that. The limiting factor is not the time but the level of investment that is available nationally in that budget.

Q41 **Dr Cameron:** Do you feel that all nurses should have investment in their CPD in order to develop?

Daniel Mortimer: All nurses have to have investment in their—

Dr Cameron: Except for the mandatory part. I refer to the bit that helps them progress, feel valued and develop.

Daniel Mortimer: There is a mandatory part that we have to do for all staff. There is an element that is absolutely required for people to maintain their registration and, as an employer, we have a responsibility

to support that. Then there are the things that people need to function within their role. That third bit is where we believe we are much weaker than we used to be because of the disinvestment in the national training budget.

Q42 **Dr Cameron:** Okay. I will finish by asking about mental health and community nursing—areas you have highlighted—and mental health in acute wards, where I understand there is understaffing. What is happening there, what needs to be done and why are people finding it difficult to stay in those jobs? We need them.

Jane Beach: It is a very stressful branch of nursing and there is not always the support there. Practitioners used to have schemes such as restorative supervision but, with a lot of the cuts, things like that are going, so there needs to be more support to enable people to cope with what is a very difficult job. Among our members, what came out top was stress in the workplace and being able to do the job that they have trained to do and to the level that they want to do it. We need more investment.

Q43 **Dr Cameron:** Do we know whether there are more Datix incidents in those areas? Are staff more likely to experience abuse at work, or threats or assault?

Jane Beach: They are, yes.

Daniel Mortimer: In the mental health sector, yes.

Janet Davies: Of course, we also have the issue with NHS Protect, which has now gone. We have lost the investment in that, which means that we do not get the overall picture that we used to. We get some good data from employers, but that independent body looked at assaults on staff, at the sectors and at levels of prosecution. That has been removed this year—another of the things that support nurses in which they feel there seems to be more disinvestment than investment. It certainly feels that way with some of the useful add-on extras that are very important for staff, if not seen as obvious by others, maybe.

Daniel Mortimer: It is quite an interesting dynamic. Two reports have been published. HE published a workforce plan for mental health, and my colleagues in the Mental Health Network at the NHS Confederation published something on the workforce. There is something about resetting and restating the status of mental health nursing in particular. Lots of young people choose to do psychology degrees and have a real interest in mental health, but they are not choosing to train to be mental health nurses in the same numbers. It is for us, with the profession, to think about how we make it clear that a career in mental health nursing is an attractive career, a rewarding career. There are fantastic opportunities in terms of career development. There are some things we need to do as a service with the RCN and others to make that case.

Janet Davies: I would say that mental health has been disproportionately affected by the introduction of the student loan

system—there is no longer free education—because it is often a more mature person who will come into mental health nursing.

Chair: We are going to look specifically at the impact of the bursary change.

Janet Davies: Right, but it certainly makes a difference on mental health nursing.

Chair: It is a major theme. Before we move on to the theme of pay, Andrew has a point about mental health and social care nursing.

Q44 **Andrew Selous:** Sharon, you talked a lot about the importance of parity of esteem. Could you give us maybe four or five pointers? You told us earlier that there are 8,000 fewer nurses in social care. What four or five things do we need to do to reset recruitment for nurses in social care?

Sharon Allen: The first thing is to recognise the nurse role in social care in all its various forms as something that is equal to working in an acute hospital or a community setting. Unfortunately, we still hear anecdotal stories that when nurses are training they are encouraged to see the acute sector as the first choice to go to and then, if a job is not available there, into primary care, and only to consider social care if there is nothing else. We absolutely have to change that. We need social care to be seen, as colleagues have articulated, as a hugely rewarding, fulfilling role when you can support really well someone who is living with dementia or support someone in end-of-life care.

An example from my past is when somebody with a profound learning disability and complex health needs needed dialysis but, because of their complex learning disability and behaviours that challenged it, it was going to be incredibly difficult to go to hospital. The nurse there advocated for them, contacted the National Kidney Foundation and managed to persuade everybody that they could manage home dialysis, which made a fantastic improvement to the person's quality of life. We need to get those stories out there.

Secondly, we need equity of investment in workforce development and continuing professional development for nurses working in social care, and that needs to be easy. We managed to make the system incredibly complicated between us, and even understanding who to contact and how to access things is incredibly difficult. It is important to make that simpler.

There are about 2,500 residential nursing care homes in England, and domiciliary provision and other provision. Many of them would be delighted to offer placements to trainee nurses, but again we need to build the infrastructure to enable them to do that and contribute fully. We need to show the career pathways. People often talk about social care having no career pathway. I do not believe that. I started as a social work assistant. There are many examples of people coming into social care and, as we said earlier, of people coming into those leadership roles.

The fifth area is to be really clear about the practice leadership role that

nurses in social care have and can take supporting their workers. There are, I think, about 43,000 nurses working in social care, out of a total workforce of 1.45 million, so the opportunity to be influential and share that practice leadership is—

Q45 **Andrew Selous:** That is very helpful. I am sure there are a couple of issues on which the Committee will want to follow up. May I ask the same question of the other three on the panel? What four or five things do we need to do with mental health nursing? We have heard there has been a 13% drop, so, specifically on mental health nursing, will you give us a couple of headline pointers?

Janet Davies: It is very much the same as we have been talking about more generally, and I have been including mental health in my responses. There are things that are very specific, though, about seeing the value of mental health nursing and giving more prominence to the role and the difference it makes in people's lives. It is stories of the difference that they can make that will bring people into the profession. It is key that we focus on how we are going to bring the best people into mental health nursing and on how we are more flexible, offering more opportunities to move into mental health nursing from either a social care setting or as a general nurse. At the moment the pathway starts quite early, which is good because people get into the area they want to, but later in their career there needs to be far more flexibility for people to move. Mental health nursing does not always appeal to an 18-year-old leaving school or going to university. It is a difficult area and sometimes you need a little more experience, but certainly it is something that people might wish to do later in their career. I know even myself—I am a mental health nurse but I trained as a general nurse—that it was my mental health placement when I was a student nurse that convinced me I would rather like to do this. We need to have much more of those opportunities again now.

Andrew Selous: That is very helpful. Thank you very much. We appreciate that.

Q46 **Chair:** We now come on to the issue of pay because, interestingly, it was not in the top three reasons for nurses leaving the profession, according to the NMC. Janet, may I start by asking you to set out how important pay is both in recruitment and retention?

Janet Davies: I think it is more important in retention than it is in recruitment in some ways, because when people come into nursing they are not thinking about what that means to them unless, of course, we are bringing them in from other professions and roles, in which case they cannot afford to do it because they would take too big a drop in pay. We are seeing that there is real hardship for some nurses. It is true that nurses are now struggling to pay their bills because every single bill has gone up: their rent—if they are lucky to have a mortgage, it has not really changed—and childcare have changed, their bills have changed and transport to work has changed, yet they have not seen an increase in their salary for so many years. We know the average nurse is now 14%

worse off in real terms. We know it is a causation factor of them leaving. It is not the No. 1 frustration, but it is the No. 1 frustration in their life, if not necessarily in their work, and they do not always put that together.

We know certainly from all the evidence we have gathered over our pay campaign over the summer—we have provided so much evidence—what difference it is making to people who are struggling. If you are worrying about paying the bill when you are trying to give all your attention to someone else's problems, it becomes really difficult to do your job well.

The big message, I think, is that they feel they are not valued. If nurses are being told that because of austerity measures they cannot have an increase in their salary that matches inflation, they do not feel valued. It adds to everything else, so 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 that time. Pay is the one thing that could make a difference instantly. Everything else will take some time. It will take time to get new nurses trained. It takes a minimum of three years, and that is for the normal graduate role; it is longer for apprenticeships, longer to grow them in different ways. One thing that could give a message is to give them a decent pay rise that is above inflation and starts to make up for the lack of investment.

Q47 **Chair:** How concerned were you by what we heard from the Secretary of State that pay rises might have to be linked with productivity—in other words, not new money? What impact would that have?

Janet Davies: It depends what is meant by productivity. If you have a well-paid workforce, they will feel better about their work. We may not lose as many and, therefore, productivity will increase, but when you have hospitals and communities working to their very top I cannot see what more productivity you will get out of that. Nurses are working solidly. What you might see is that, if you have more nurses in the system because they are feeling valued and they are not leaving, throughput would be better and we may not have to start closing areas. We are already seeing some areas closing facilities, even temporarily, because there are not enough staff. That is clearly poor for productivity. The biggest risk would be any pay rise being paid for out of an NHS budget which already is not sufficient to provide care. That would be totally wrong, and nurses would feel guilty about it. It is not for nurses to pay for the NHS.

Jane Beach: It is the whole message it puts out: you can have a pay rise if you increase productivity, whatever that means. It may well be that that is changes to terms and conditions, but it is the whole message that then sends to already struggling, hard-pressed nurses: we can have it but we have to give something up in return. It is not the right message. It is about respect. We need to respect the nursing profession, and paying a decent wage is part of that.

Sharon Allen: On the issue about pay increases, it is very important that

anything that is talked about in relation to public sector workers also recognises the social care workforce, who predominantly are not public sector workers but are providing a vitally important public service. Again, it is that parity and not doing anything that is going to exacerbate the gap that already exists between the terms and conditions of colleagues working in the NHS and those working in social care.

Daniel Mortimer: Employers report a similar concern to the one that Janet described. We have had two years of no pay awards and five years of minimum pay awards, in common with the rest of the public sector. That is not a sustainable position, but it clearly also is not sustainable for the NHS to be asked to find funding for that pay award within its own resources. We all need to see what the Chancellor says when he stands up to give the Budget and what message he particularly gives the NHS and our two pay review bodies for doctors and non-doctors.

We share with trade union colleagues some aspirations to reform our contracts. We also share with our profession some aspirations in how we maximise the contribution that professionals can make. That is probably less about the contract and pay, and more about some of the rules and conditions we set for people, which I think sometimes limit their practice and their ability to innovate. There is a real interest that we would share with our trade unions about how we move that forward, but we are very interested in what the Chancellor stands up and says. I think the biggest risk—I am sorry to repeat myself—is something above the 1% pay cap but that the NHS is asked to find that money itself and within its own resources. That just is not sustainable for us, as Janet said.

Chair: We are now going to come on to working conditions, unless, Lisa, you have any further points, or do you think that was all covered?

Q48 **Dr Cameron:** I think we have covered most of those issues, although I did want to ask about the importance of flexible working and work-life balance. I will leave it to the panel to decide who should answer on that.

Janet Davies: It is incredibly important, particularly for people with families and other commitments. We find that a lack of flexibility drives people into working for agencies and banks, which are more expensive—agencies in particular. I know that employers have been doing this work, and there are signs in some areas that it is getting better, but it is not universal. We are still finding places that say you can work a 12-hour shift and that is the only option. We have talked about technology a little, but we have not realised the potential of computerised rostering systems, for instance, where there is not enough investment in the education and development of how to use them. People transpose the old shift patterns on to a computer so that all they are doing is what they have always done but with a computer. We have not maximised the potential of someone working two, three or five hours and of mixing that. We are keen to work on that alongside employers. There are some outdated practices, without people realising it, but there are signs that people are listening.

Daniel Mortimer: The flexibility that a lot of our nursing workforce are looking for is predictability. They are not able to work the kind of rotational shift patterns that we typically expect a ward-based or community-based nurse to work, and they are looking for greater predictability. The balance there if you are a line manager—if you are a nurse managing a team—is that if you start to make something more predictable for one part of your workforce, you make it perhaps less advantageous for another part. Our line managers have a very difficult balancing job to do. I agree with Janet that we could make better use of technology. Where it is being used well, with that kind of electronic rostering, and we see managers and their teams being able to use the technology to develop fairer working patterns, we see some tremendous success. We are a lot better than we used to be, but there are still places within the nursing workforce where some attitudinal change is needed to provide that predictability, particularly for colleagues with caring responsibilities. It is the people who need to plan their lives, frankly.

Q49 **Dr Cameron:** I had experience of that myself when I came back from maternity leave and asked for flexible working, to go down to four days. It was granted, but I was told I would still have to see the same number of patients and that no one would be covering the extra day. To what extent is that culture still prevalent, and to what extent do you feel that true flexible working is being afforded to staff?

Janet Davies: It is better in some places, but it is still happening. It is a mixed picture. Many employers understand that that is not a good idea, and I do not think that it is necessarily organisational policy. It is a mixed picture and quite often it is within a unit rather than with a whole trust, for instance, but we do still see that. Of course, it totally undermines what you are trying to do because we will lose that person and we are trying to keep as many people as possible. Particularly at times of life change such as maternity leave, when you come back, you are not necessarily going to want to work in the same patterns that you worked before you had your family; so that is a really important issue.

Sharon Allen: We hear from nurses who stay and enjoy working in social care that one of the things they enjoy is the greater flexibility. Again, it is not everywhere, but there are some services where people are doing much more self-rostering and self-managing—the team are kind of working it out together—which is a really helpful thing.

Daniel Mortimer: There were a set of attitudes as well that we are constantly trying to change. Some of it is about the "not in my day" attitude and, "I reduced my hours, but I still saw as many patients; so I am going to expect you to do it." There is something about letting go of what was perhaps unfair in the past and recognising that there are different ways of doing things. Again, as Janet said, the organisations that do that well, or the line managers, who are usually other nurses, have embraced the fact that perhaps it is different now from what it was

20 or 30 years ago. We see progress, but we still have variation that we need to tackle.

Chair: We are going to come on now to the issue of the changes to nurse training and nursing bursaries with Diana.

Q50 **Diana Johnson:** Do you think the changes to the way that undergraduate nursing degrees are funded will deliver on what the Government want to do, which is to increase the number of nurses?

Janet Davies: We have been pretty vocal about it from the beginning. Removing that funding for nurse education, particularly at a time like this, was a dramatic mistake. We have seen a reduction in applicants. It is varied. We have seen a variation in the number of students who have started. It is different in geographical areas. We have even been through clearing for nursing places in some areas, which is quite unusual, in order to bring people in. As I say, it is a mixed picture.

We are not seeing the number of more mature people coming into nursing who are so important for our profession, and we have seen a significant reduction in mental health and learning disabilities—learning disabilities, in particular, because we want to increase the number of learning disability nurses. With regard to some of the figures that we know, London South Bank University, for instance, which is a very good educational institution, is not even going to run the programme for learning disabilities this year because it has not had enough applicants, so we have lost a programme.

The other thing we see is that, because of this, many of the universities are changing the way they bring their undergraduates in. They are not having a spring intake. They are having their September intake, which is the same as all the other students, but traditionally many would have a spring intake as well. You would have two intakes a year, which means you have a much better supply of newly qualified nurses. Quite a number of universities are freezing that spring intake, which we think will cause some real problems in continuity of new people.

We think it has been an absolute mistake. We thought it was from the beginning and we still do. It does not mean that we do not agree there should be other routes. We have never felt that it is the only route, but it is the tried and tested route, it is very safe and it is proven.

There is a role for apprenticeships, but we have a great concern about how an apprenticeship model will work and what it really is. Apprenticeships need significant investment. It is not a cheap option, and the current focus on those organisations that are already struggling to provide care to take the responsibility for this worries me greatly, because their focus is on provision of care. It is complicated providing education. It is based in universities. In fact, many institutions changed to universities to ensure that the education was of the quality that they needed it to be. But, of course, the levy for apprenticeships is not the

only thing. If you are a true student, to be a professional, such as a nurse, then you have to be a student. Even if you are an apprentice, you are an apprentice student; you are always supervised and you have your rotation like any other industry or profession, and therefore the money that is lacking is the backfill for that individual. An employee is taking on that role, while the apprenticeship levy is just not enough to enable the supernumerary role for a learner.

We are worried. It is early days, but we know already from the discussions that we are having with providers, both in terms of the NHS trusts and the universities, that this model is not yet worked to a level where we can be absolutely sure of excellence. It is early days, but it is being seen as an alternative model. We believe there are always ways of bringing people into nursing in a more flexible way, people who might not want to train in a different way, but it needs to be seen that it is a good-quality and well-resourced alternative. It is not something to be done on the cheap or to be given to those people who are least likely to do it. That is where we stand particularly on that decision.

Daniel Mortimer: I would echo that. As employers, we believe that the nurse apprenticeship route is a useful and interesting route. It 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. Actually, it is a very slow growth. We will see a major expansion in nurse apprenticeships next year. It is two institutions this year and we will see a dramatic growth next year, as Janet said.

If we look elsewhere in the UK—and this is perhaps a divergence between the RCN and ourselves—we also see a decrease in nurse applications in those nations that have kept nurse bursaries. Northern Ireland, Scotland and Wales are reporting a decrease in nurse applications, and the recent report from the Health Foundation that Anita Charlesworth and Jim Buchan did highlights that. The policy was introduced very quickly in England, which meant that the extra money for clinical placements was announced after universities had commissioned their places that were available, and this is unfortunate in terms of the first year.

Our biggest frustration as employers over many years has been that conversation we had right at the beginning of this session, which is that the money that the NHS had available to fund education was the limiting factor in the number of nurses that were available. We want to move to a sustainable system where there is not that cap, if you like, on the number of nurses or physios that are being trained. As you already touched on and as Ms Berger touched on in terms of our history in trying to plan the nurses that we need in five or six years' time, it is not a glorious one and we wanted something that would move beyond that artificial limit that we

set ourselves on universities. Removing the bursary was the way in which the Government believed that could happen within England. It was then implemented very quickly.

There is something more fundamental for the longer term across the UK, which we touched on already, about the image of nursing in mental health. That is true. We need to have a different conversation with the population about why they should choose nursing as a career, and I hope in this 70th anniversary year of the NHS, by working with the profession, we can start to market our careers slightly differently than perhaps we have done in the past.

As we have touched on here, the roles and opportunities that are available for nurses are very different from when my mum trained to be a nurse 50 years ago, and there is something about resetting the narrative and image that we have for nursing that, hopefully, will reverse the decrease that we have seen before the bursary changes were implemented and that we are seeing in other parts of the United Kingdom outside England.

Jane Beach: I would like to add, particularly around the apprenticeships and the bursary, which are linked, that we need to be very careful that we do not introduce an unfairness in the system. If you have been through the apprenticeship route you won't have any fees to pay, whereas if you have been through the traditional route you will come out with a massive student debt, and yet you will both be on the same salary when you qualify as a nurse. We need to be mindful of that.

We support the apprenticeship route. The levy can only be used for training and not for salaries, so there is a concern about whether employers will go for it—whether they will be able to. But I absolutely agree with Janet. We were opposed to the bursary being removed, particularly because those people who traditionally would have gone into nursing quite likely already have a student debt. Who would want to saddle themselves with another student debt? It just doesn't make sense, really.

Janet Davies: I perhaps have a different interpretation of the limiting factor of the number of nurses we were bringing in and the number of nurses we were training. I do not think it was a limiting factor. It was a total lack of investment. We make a choice of how much we want to invest into our health service, and part of that is how we train our healthcare workforce. Actually, it was limiting, but I think it was limiting because not enough investment was going into training our student nurses. It is the same issue but perhaps a different interpretation.

Q51 **Diana Johnson:** You have given very full answers. I had a couple of other questions, but I want to ask you one particular thing. The briefing note that I read talks about the idea of the abatement of any loan that perhaps a student nurse would have if they then followed it with a three-year or five-year period of service. What do you think of that idea

as a way of trying to ensure that people do not have a lot of debt?

Jane Beach: It is what they do in Wales and it seems a reasonable idea because you have job security at the end of it. In Wales, they say, "We will fund you if you work for two years," I think it is. It is a good deal to have job security at the end of it and know you have got a job.

Janet Davies: A forgivable loan system is good, but that funding still has to be found. Whether you take it out at the beginning or give it back at the end, my worry is that yet again it is putting the cost on to the NHS provider, because I would suspect it is the trust that will have to find that money to pay those staff. It is just a transference of the cost to the people who can least afford it. It is still the same money. It is even more worrying that there will be a whole load of debt in our system that will never get paid off. Although I am fairly ambitious about pay rises for nurses, I cannot see the average nurse ever paying off a student loan. I would have thought that is even more worrying to our economy than investing in the first place.

Q52 **Chair:** Is there any work going on, tracking what is happening to the mature nursing workforce coming in? As you have commented before, Janet, there is a lower attrition rate in mature students who come into nursing. How well do you think this particular group of the workforce is being tracked and what is happening to them?

Janet Davies: It is difficult to know for this year because we still do not have true figures. We are finding it difficult to get them. We have been going to individual universities and getting some response. It is absolutely essential that, whatever has happened here, we track from the very beginning how long people stay and what their career is, including the new apprenticeship routes and what opportunities they have. It is so important, I think, because we are developing a two-tier system and we need to ensure that there are equal opportunities all the way through. We do have some worries about that, particularly for those more mature people, but we start from now really; they have only just started. But we certainly know the figures from the past.

Chair: We were also going to talk about the apprenticeship levy.

Diana Johnson: Yes. I thought the panel had really addressed the apprenticeship levy about how it was not really—

Chair: Yes, I am sorry. I wondered if you had any other points on that.

Diana Johnson: The panel were very comprehensive in their answers.

Chair: Yes; thank you.

Q53 **Dr Caroline Johnson:** How do you see nursing associates as adding value to patient care?

Janet Davies: We heard from Sir Robert Francis about the education of healthcare assistants or the lack of education and regulation. What is

really positive about the nurse associates is that we have assistants to nurses who have gone through a regulated programme and are accountable and regulated. That is something that we have been wishing for for a long time, but that is where it finishes.

There are two things. One is that they are not registered nurses and, therefore, should not be used as a substitute. They are there to support the registered nurses and we must be very careful that the skill mix is safe for patients. We also need to ensure that we do not have three levels of nurses—that healthcare assistants get the opportunity to do this. In other countries they have the nurse associate-type role and the registered nurse, but they do not then have people who do two weeks' training and happen to work in our hospitals. They have the two areas. We seem to want all of it.

There is something about how we reduce the number of healthcare assistants who have not had any education, so that you have the care certificate as level 1 and then the nurse associate. When those nurse associates are qualified, those who want to become a graduate nurse get the opportunity for further education. I see this as a role that might bring people who might not otherwise have thought of being a registered nurse into being that graduate. I have met a few of the nurse associates who have started this year, and certainly the group I met recently was very ambitious. Some of them had worked as healthcare assistants for 15 years. This has been a great opportunity for them, but now that they have had nearly a year, I guess, they are saying they feel confident that they want to be a registered nurse. So, we must make sure it does not stop here and that we have the two-year programme that enables them to become a graduate. It is a great opportunity for growing our own workforce. We have all sorts of concerns around it, but if it is done well it will be good.

Daniel Mortimer: There are examples that pre-date the nursing associate initiative—the formal initiative—which has led to the regulated status that Janet has described where what we call the assistant practitioner roles, working in nursing teams, worked alongside nurses, and it often meant that nurses could step back from roles that they were being asked to do inappropriately but could still supervise and lead care.

As Janet said, there are some opportunities there. We are still in the pilot phase in the NHS, and we need to see how those pilots play out. We also need to understand—this is a variation on a point you were making earlier about the nursing workforce—the pressure that places on our healthcare assistant workforce, both in the NHS but also for Sharon's members, because we are putting in place a career structure in the NHS that will change the job market quite profoundly, both within the NHS and in that bigger care workforce, and we do not quite know how that will play out just yet.

Sharon Allen: Some of the pilots are taking place in social care, and we are getting very positive reports back and reports about the calibre of people. It is an important part, I think, of career development for both healthcare assistants and people working in social care. Social care providers are very welcoming and want to see this as part of their career pathways for colleagues. The important thing is the clarity about roles and standards, what different people will be able to do and where the supervision comes in.

To answer your question about what it will mean for people who need care and support, whether in the health or social care sector, as long as it is developed properly and there is clarity about standards, responsibilities and supervision, we welcome it as a positive development.

Jane Beach: I would agree with all of that. The only thing to add—it is probably one of Janet's concerns as well—is that we were always concerned about it being used as an "instead of." Unfortunately, we have heard of an organisation locally where they are planning to reduce their registered nurse workforce in favour of having more nursing associates. That is the only caveat I would add. As an "as well as" it is a fantastic opportunity, but as an "instead of" absolutely not.

Q54 **Dr Caroline Johnson:** That brings me on to the next question, which is, what risks do you think are associated with the introduction of the new role, if any?

Jane Beach: I think that is one of them. It is seen as an opportunity to have a cheaper workforce, and unfortunately, especially in the community, that is what we are seeing. They are favouring having more support roles and fewer registered roles. That is one of the risks.

Sharon Allen: There is also the risk of further confusion for people who are using services. That plays to the point about being very clear about the standards and responsibilities, and being clear about who is performing what role in whatever type of organisation it is.

Daniel Mortimer: The risk is that we make judgments and perhaps fear worst outcomes before the pilot process has even finished and the profession and the NMC have set the appropriate standards, but I think they will. I do think there is that need for clarity, but I also think there is that need for recognition that there are situations where we ask trained nurses to undertake work that they should not be undertaking and there are other people who can take that on under their supervision and their leadership. That is the important caveat.

I would also say that there is a long way to go in the development of the nurse associate role. Janet is right that we need to approach it positively, but we need to be clear-sighted—Sharon expressed it better than I can—about the standards, clarity and boundaries of the role. I think the vast majority of employers in the NHS share that goal and aspiration for the role.

Q55 **Dr Caroline Johnson:** You mentioned in both your answers that the nurse associate role offers an opportunity for nurses not to have to do tasks that are "inappropriate", as you describe them, but the nurse associate could do them instead. What sort of tasks do you mean? What do you envisage the nurse associates doing?

Daniel Mortimer: We commissioned the Nuffield Trust to do a report on new ways of working in the NHS, which included examples from primary care. One of the case studies in that, which is of a mental health provider in Bradford and which pre-dates the nurse associate initiative, is that nurses were being asked to do fairly straightforward physical assessments of mental health patients. The nursing team—and this was something that the nursing team led—introduced an assistant practitioner role that did that assessment on their behalf and the nurses were freed up to meet more complex needs for that client group. Therefore, there are settings where nurses have led changes to practice that have involved nurse associate-type roles, where the nurses could concentrate on the areas where their skills and professionalism were best used but were supported by a team that could help them in that regard.

That is the example of which I am most aware, and there were other similar ones, particularly in mental health settings where people have been working in that way and developing those roles for some time. It is not an absolute; it will not work in every setting and it will not work with every type of patient. There are settings within acute hospitals where that role just would not work because it is the trained nurse that you would need in almost every situation and every circumstance.

Q56 **Dr Caroline Johnson:** You would certainly need to make sure that you had a trained nurse to interpret the information that followed.

Daniel Mortimer: Absolutely. The reality of healthcare is teams, and those are often teams that are led by nurses. It is about understanding how this role can help that team and may support the nurse in their practice. That is the bit that I guess we need to understand from the pilots. We should not assume that it is going to be the wrong outcome—that it is going to lead to a reduction of the care we provide to patients. It may well mean that we can use nurses more appropriately and in a more fulfilling way for their practice.

Janet Davies: The danger is that this is being introduced at a time when we are so short of nurses that inevitably people are looking at that as a solution to the shortage of graduate nurses. That is the worry, because it is happening at this particular time and obviously people would rather have someone there than nobody. But also, with the financial situation of most organisations, we already know that people are looking at this as a cheaper nursing option, which is totally unacceptable. That is what happens when you introduce something like this when we have such huge economic pressures and financial difficulties in our NHS trusts. That is the danger. It doesn't mean it is going to happen, but I would predict—

well, we already know that some places are already looking to do that, which isn't really what this is about.

The other thing, of course, is that it isn't a quick way of growing nurses, so we have got a real crisis. The quickest way to get more registered nurses is to put them through a three-year programme—which takes three years; it is well tested and they will come out as a nurse. The alternative models also could be very good but they will take longer. This is not a quick solution, because for a nurse associate it will be two years and then probably another two. It will be four years—probably five, because they will have a period in between.

The other worry I have about the nurse associates is that it has been very much a politically led initiative and I worry that these things disappear in the future, and that these individuals who have been recruited, thinking that they will get the opportunity to be a registered nurse, may get stuck at that nurse associate level if things change, without the opportunity to do that next level, which has happened previously.

Q57 **Dr Caroline Johnson:** Do you think they differ from the advanced nurse practitioner? We talked earlier on about the advanced nurse practitioners in terms of working numbers, but as I recall, as a junior doctor, when they brought in the European working time directive, there was significant pressure on medical workforce numbers inasmuch as doctors could not work as many hours and they had rota issues.

One solution was that some of the trusts in which I worked, and at which Daniel was the HR director, used advanced nurse practitioners to fill those roles—something that he pointed out helps to retain nursing staff because they feel they have a career progression, and you support that. So, how is that any different from using nurse associates, who are effectively healthcare assistants with additional skills, to do some of the nursing roles for which they are qualified and which may provide the patient with the care that they need when they need it?

Janet Davies: It isn't any different, and that is why I am saying it is the whole career pathway. One danger is that they don't get the opportunity, from being a nurse associate, to progress to become a graduate nurse, which is what many people who are coming into this role see as the future because that is the way it is being sold. There has been an expansion before we have even evaluated these as one of the solutions suggested for the current workforce shortages. I don't say it is going to happen, but one of the dangers is that people might then get stuck. It is certainly what happened with enrolled nurses, and we would hate to see it happen again—they should have a continuing career up into wherever they want to go. Of course, we also know that there are not as many advanced nurse practitioners supporting some of those roles, but it is the physician's assistant that is now becoming the model of choice for many of those roles to support doctors.

Daniel Mortimer: I do think—Sir Robert made this analogy in his evidence—that nurse associates are not enrolled nurses; they are not nurses. Enrolled nurses were nurses and they were on a different register. We made them wear bottle-green uniforms and we didn't treat them very well or very respectfully, which is one of a whole set of reasons why we moved away from that, and I think quite rightly. This is not a nurse. That is perhaps the difference. I think there are opportunities and we should be positive about them, but it is not an absolute; it will not suit every setting or patient/client group, but it is a way of supplementing the team and supporting the nurse to advance or extend their practice. It is part of that team package. But even though they are going to be regulated by the NMC, they are not and will not be a nurse. That is an important distinction that we have to reinforce, and that kind of analogy going back to the enrolled nurse is just unfortunate. It speaks of our past and it is not a particularly happy past in terms of how we treated that workforce, I would say.

Q58 **Chair:** One problem is that there are so many moving parts at the moment. May I touch on a point that you mentioned earlier about this not being a rapid route into nursing? Should we make greater use of APEL—the accreditation of prior experience and learning?

Janet Davies: Yes, absolutely.

Q59 **Chair:** In other words, are we not taking enough account of people's long experience?

Janet Davies: There are two ways in which we can speed up bringing people on to the register—and certainly graduates. One is the healthcare assistants who have lots of experience, who do not need to go through the nurse associate route, but with APEL they could do a shortened programme to become a graduate. That is a really good opportunity. It is not without its difficulty in funding, but it would be a very good investment. The other, of course, is the graduates who want to become a nurse.

Q60 **Chair:** The Nurse First route.

Janet Davies: Yes. We have the Nurse First model, which I know you have examples of already, but we could significantly expand that programme. We know that many graduates would like a career in nursing, and at the moment it is small numbers. Those are two years. Those are the quicker programmes to expand the workforce quickly.

Q61 **Chair:** Do you see that as being a good route particularly to expand the mental health nursing workforce?

Janet Davies: Absolutely.

Q62 **Chair:** In evidence we have heard about the Nurse First programme.

Janet Davies: Absolutely. I think it works for all specialties, but at the moment the concentration is on mental health and learning disabilities,

particularly because of the reduction in people applying through the university route. We know that some of those people will already have a degree and cannot access another loan, or if they can they do not want two loans to pay off.

Q63 **Chair:** They will have the equivalent of a bursary for teachers to train in—

Janet Davies: It will be a bit like Teach First, bringing in some of those graduates who want to become nurses and shortening that programme.

Q64 **Chair:** Before we move on to the EU, Brexit and other issues to do with language testing and so on, may I quickly touch on whether you have any concerns about a group that might have been left behind in all this—associate or assistant practitioners? Do you feel that that role will now disappear altogether and they will all transition into nursing associates?

Janet Davies: They are very different and very specific roles. Danny was talking about one in mental health. There are many who have been developed and educated for a specific role to meet a specific need in an area, which is very different from the nurse associate, which is very generic. It is there to meet a local need and is not always transferable, but sometimes it is. Some have a concern not that they are getting left behind necessarily, because they believe that they are a band 4 and the new nurse associates will be a band 4. They do not necessarily want to be nurse associates. Where they have a concern is that the nurse associates will be regulated and they are not going to be regulated. We are already talking to the NMC as to what we can do about these individuals, because we believe all the workforce should be regulated. I think they will get left behind on regulation unless we can do something about it, but their roles are different.

Q65 **Chair:** Would that be a clear recommendation to this Committee?

Janet Davies: I think it would be a very good recommendation to keep those people in the workforce as well, of course, because they are doing really good jobs. They are not necessarily nurse associate roles.

Sharon Allen: Regulation is an issue, and of course a massive one for social care. If you add up the number of regulated professionals working in social care—nurses, social workers and allied health professionals—it is fewer than 100,000 out of a total workforce of 1.45 million. So, it is a very significant issue across social care if that is the direction of travel.

Q66 **Mr Bradshaw:** Perhaps you could each give me your assessment of the impact on the NHS, social care and the workforce challenges you already face in particular of the three basic scenarios: hard Brexit, soft Brexit and no deal.

Janet Davies: We are already seeing changes. We are already seeing the effect of Brexit on the nursing workforce. We are not seeing European nurses applying in the numbers they were. There are a few still applying

but not the number that we would have had previously. We are also seeing people leave. We have certainly seen them leave the register. The NMC's figures just a couple of weeks ago demonstrated that European nurses are choosing to leave. That uncertainty is significant, and when I talk to our European colleagues they have a lot of choice as to where they might work. There is a worldwide nursing shortage, so this is in the context of the fact that there is nowhere with lots of nurses and they do have choice. At the moment, because they want to build a career—it is not just about short experience—they are choosing to leave. That is hugely worrying because of the numbers that support our NHS and even more support social care. It will be quite devastating for our workforce.

One really positive thing is the fact that, certainly for registered nurses, directive 55 has meant that nurses have the ability to move across Europe knowing that they have adequate, if not excellent, skills and can transition very easily into different settings across Europe. It would be very sad to lose that talent in the future as well.

Jane Beach: The other thing to add to that is the potential for it to affect the diversity of the workforce and whether the workforce will then match the population to whom we are delivering services.

Sharon Allen: In social care, about 16% of the nursing workforce at the moment are non-British EU, and that has increased since 2012. We have not seen any dramatic change yet—I think it will be a different time lag for social care—but, given the extreme pressures, particularly on retention of nurses in social care, we cannot afford to lose any more.

Daniel Mortimer: A softer Brexit that still allows the mutual recognition of qualifications, as Janet has described, would be enormously helpful to health and social care. In a "no deal" situation, we would lose that scenario, and that would be a massive challenge to our regulator in how they would respond to that. I think it has a particular set of challenges, as we have talked about previously, for Northern Ireland, given the nature of its workforce and the border issues with the Republic.

The question that cuts across a hard Brexit, or cuts across all three scenarios, is that, whatever migration policy we choose to have in the longer term as a country, if the conclusion that people working here have come to is that what the population wants is greater control over migration, what we need to see, as a sector, is a control over migration that recognises the particular needs of our sector and the value that needs to be placed on the work that nurses and other workers from around the world do in providing care to our communities.

We currently have a system for managing non-EU migration that assumes that the more you earn, the more valuable you are to the country, and that is utterly inappropriate for the needs of our sector. It may help us recruit doctors, which would be great, with great respect to medical colleagues on the Committee, but it will not help us recruit nurses, allied health professionals, care workers or domiciliary workers.

Those are the people that we will need to be able to recruit for some significant time. That is the fundamental challenge in any scenario relating to Brexit.

Q67 **Mr Bradshaw:** When I tweeted those figures you referred to from the Nursing and Midwifery Council, which were dramatic—an 89% fall in nursing registrations from EEA countries and a 67% increase in those leaving—and when I tweeted the Nuffield Trust's report today that said that a "no deal" scenario would mean chaos for the NHS, I got all these Brexiteers coming back to me saying it is all because of the new English language requirements that were introduced. Would you care to comment on that?

Janet Davies: No. It is very important that people feel reassured that nurses coming from Europe can communicate well in English, which is why it was introduced for European nurses. It has always been there for nurses from elsewhere. There has been one element of the test that has been difficult for nurses, but it is only one element of it, and I know that the Nursing and Midwifery Council is now going to look at alternatives for that. It does not answer the reason why people are leaving.

Q68 **Mr Bradshaw:** So it is definitely not the reason why we are seeing this exodus and people not coming. It is not the language test.

Janet Davies: No, because they are already here, they are working and they do not have to do the language test. It could be a reason why people might not apply here. They are not applying. It is the applications to the register, not those people who have failed the test, and the people who are here do not have to do that test. They are already here and employed. They have often done the test, but they are leaving.

Q69 **Mr Bradshaw:** Thank you for that helpful clarification. It will help me respond to these trolls.

Daniel Mortimer: As to recruitment, clearly, as employers, we have not been able to recruit the numbers that we were recruiting up until 18 months ago. The value of sterling seems very material. People are choosing to work elsewhere in Europe. With the uncertainty that there is, we cannot answer the question for people of whether they can stay. The language test is a factor, but it is not the predominant factor. It is a bigger factor for non-EU recruitment than for EU recruitment. As Janet said, there are some improvements being made there.

Q70 **Mr Bradshaw:** Given that even under the best-case scenario that you outline this is going to be a negative for the NHS and social care, not least to the workforce, and given that there are an increasing number of leading parliamentarians and commentators who think that Brexit now can and should be stopped, why do you still have a policy, as organisations, of arguing for a soft Brexit? Why are you not opposing Brexit altogether?

Janet Davies: As an organisation, we have not taken any stance either before the referendum or since, partly because of the fact that we are a Royal College and we have rules about specific political positions, but obviously it is something that we can always review.

Q71 **Mr Bradshaw:** What about Unite, because you are a union and you take positions on everything?

Jane Beach: We are. I am on the professional side, not on the industrial side, but we are a membership organisation, so we have to be mindful that we will probably have a large percentage of our members who voted for Brexit. I cannot answer any more than that really because it is way out of my comfort zone.

Q72 **Mr Bradshaw:** Perhaps you will take the message back to Mr McCluskey that he also has a duty to lead and explain to his members what impact this is going to have on their lives and on the NHS.

Jane Beach: I will, yes.

Q73 **Mr Bradshaw:** What about the professional employer organisations?

Sharon Allen: We are a non-party political and non-political organisation. It would not be appropriate.

Q74 **Mr Bradshaw:** Why is it political to spell out the negative impact that this is going to have on our NHS and social care?

Sharon Allen: That is a different point, though, is it not? Providing the data, the information and the implications is what we are doing. Commenting on whether or not we should support Brexit is a different matter, I would suggest.

Daniel Mortimer: The clear guidance from our members is that, at the moment, we have to accept the decision that has been made and the policy that is being pursued by the Government, and we have to make sure that, as we leave the European Union, the worst possible—

Q75 **Mr Bradshaw:** If we leave. This is part of the problem, Chair. It is accepting a narrative of inevitability, which I am trying to challenge here. You have just taken a political position. You have just accepted we are going to leave the European Union. That is the problem that I am trying to tease out, really, from this conversation.

Daniel Mortimer: And you have made the point to us both privately and publicly before. The job that I am given by my members is to deal with the extant policy and to make sure that, as it is implemented, you as a cohort of representatives—as our representatives—understand the implications for our sector, and that we are clear in particular in relation to that point about migration policy. Actually, that is an issue for us now, never mind when we leave the European Union, that actually we have a much more balanced approach which properly supports our sector and

which isn't geared to perhaps some other sectors of the economy more especially. That is the job that I have been given by my members.

Q76 **Dr Cameron:** Do you think there has been short-sightedness in the past, perhaps an over-reliance on bringing people from the EU to do these jobs rather than having a proper workforce plan that looks at generating healthcare workers here? I also wanted to mention, for the record, that I am a member of Unite just in terms of my registration.

Daniel Mortimer: For the record, I should mention that I am the son of an Irish midwife, who came here a long time ago. Clearly, there have been times in our history, where I grew up, when the women with whom my mum worked were largely from Ireland and the Caribbean. They had come to work in the health service. The general practitioners with whom my mum worked were largely from the Indian sub-continent.

It is not a new challenge that we face, but having a diversity of skills and backgrounds is also not a new benefit to us. Most parts of the health service are often more diverse than the communities that they serve.

At the same time, we and the work that our organisations do together through the coalition accept that there is much more we can do to stimulate the interest of our domestic population to want to work in our sector. We accept that there are parts of our communities that we have not properly reached to encourage them to work with us. We are doing quite a lot of work at the moment, for example, helping employers within the NHS to access colleagues who are leaving the armed forces.

There is much more we can do to employ people with a whole range of skill sets, not just clinical skill sets, to come to work for the biggest employer in the country. We are a relatively poor employer of people with mental health problems and learning disabilities. The NHS is, surprisingly, a relatively poor employer of young people. We accept that we must do a whole set of things to make sure that for the next number of decades the NHS and colleagues in social care as well are seen as a good place to come and work, and to pursue a career. But, actually, we have always benefited from that international dimension to our work.

Q77 **Dr Cameron:** We also have a huge disability employment gap in the UK. Could we not be encouraging people into these professions, into apprenticeships, who have perhaps not had opportunities?

Sharon Allen: We absolutely should, in particular with social care. Given that we are here to support the disabled and older people in our communities, we should be leading the way as an exemplar of employing disabled people, but we are not. We have produced guidance for social care employers to encourage them to think more broadly. We are engaged in a programme of pilot activity at the moment where we see the potential, where we are doing exactly what Danny has talked about, thinking about people who might traditionally not be seen as people to consider recruiting into social care, including people who have had

experience of homelessness or substance use, people who might have been through difficult periods in their life but are now in a much more stable place and have the right values. One of the important and effective mechanisms we have is values-based recruitment, which we know gives a good return on investment and reduces turnover. That is one of the things we have been talking about. There is definitely more we can do but are not doing at present.

Q78 **Dr Caroline Johnson:** I want to go back to the issue of Brexit and the "no deal" scenario. There is a difference between no trade deal and no agreement on anything at all, which are often slightly conflated. At the moment, we recognise nursing qualifications from the EU. As I understand it, we also recognise some nursing qualifications from outside the EU. Is that not right?

Daniel Mortimer: Nurses who come to work in the United Kingdom from outside the EU have to go through something called OSCE—objective structured clinical examinations. They have to go through a clinical examination and then they have to pass a language test. In the last couple of weeks there has been a change, which means that if a nurse from outside the UK can demonstrate that he or she has been taught or practised largely in English, they don't have to sit the language test. The allied health professions have some slightly different arrangements in terms of some institutions in some parts of the world where they do recognise qualifications, but—

Dr Caroline Johnson: But it is not automatic.

Daniel Mortimer: No.

Q79 **Dr Caroline Johnson:** Is there anything that would prevent us from recognising those qualifications that we already recognise?

Daniel Mortimer: At the moment it happens automatically for the reasons that Janet described. By law, it happens. There is an enormous consequential workload for the NMC and other regulators, but you would have to put that to Jackie Smith to get her response to a "no deal" scenario where there was no mutual recognition of qualifications. It is outside my competence.

Janet Davies: It is not automatic, but there are some areas where the education is such that it might be quicker, because you have to provide evidence of your education and skills. That always has to happen, but there is no consistency across any demographic. A directive has come from Europe and everyone has changed their programmes. As a result, the programme for nursing is different from what it was because of directive 55, as it is in Poland and so on, which is one of the last countries to meet the requirements. That piece of work took many years to get equality of education and experience, because of the number of hours of practice and so on. The position is so different across the world that it is hard to achieve. In some areas, such as the Philippines, it is quicker because some institutions train more nurses than they are ever

going to need domestically. They have a mind to that export factor. Sometimes it is easier to see the evidence of their practice, but they all have to go through that procedure to ensure that they meet the standards that we require for them to be on the register.

Q80 **Dr Caroline Johnson:** So the answer is that if we can do it for the Philippines, we can do it for France.

Janet Davies: We do not do it for the Philippines because it cannot be automatic. We do not have that freedom.

Q81 **Dr Caroline Johnson:** But we get nurses from the Philippines, do we not?

Janet Davies: We get nurses from all over the world, but they still have to go through the language test and the exam.

Daniel Mortimer: Indeed.

Q82 **Chair:** But there is nothing, presumably, to stop us continuing to recognise their qualifications in Europe if they are acceptable now.

Janet Davies: There is nothing to prevent the NMC from recognising and getting on the register a nurse who was trained elsewhere, provided they have the required education level and they pass their tests. What we do not have is an immigration system that necessarily allows them to come and practise in the country at the moment. Currently, nurses are on the shortage list but that is temporary. That was hard fought for. They came off the shortage list and that then became problematic. In order to have nurses with experience, because getting experience is not always due to workforce shortages, it is important that nursing is seen as a profession that requires a special arrangement for immigration.

Daniel Mortimer: I absolutely agree with that. That is a pressing issue now. As to the specific legal responsibilities that the NMC has, it is not as simple as them just saying, "We recognise degree courses in Portugal, Spain or Ireland," which are the three countries in the EU from which we have probably recruited most in recent years. It would require a significant change to UK law, I believe. The NMC are the people who can answer this question rather than me. EU law makes it easy for us to recognise each other's qualifications. My understanding is that UK law, as it stands, does not allow us to do that.

Dr Caroline Johnson: So it would need a change.

Q83 **Chair:** In closing—and thank you all for your written statements—is there anything before you leave today that you do not think you have been given the opportunity to put on the record that you would like to say that you believe is important for us as a Committee to hear?

Janet Davies: We have covered most of the issues that we would want to have covered. The only issue is about leadership in nursing and its complex nature at the moment. I believe that not having a chief nursing

officer sitting in Government, in the Department of Health, is not adequate when nursing faces so many difficulties and there are so many things we need to do. It is such an important role. It is one that is recognised by the World Health Organisation. That is no criticism of the person who is currently in the chief nursing officer role, who is covering three organisations at the moment. This is about a full-time chief nursing officer in Government, in the Department of Health. We lack something in what that says about nursing as the largest workforce and profession in the NHS.

Chair: That has been made clear to us in other written evidence. Thank you. That is the key message that you would like us to hear.

Janet Davies: Yes. That is a point we did not cover.

Jane Beach: We probably have covered it all, but we still have issues regarding nurses raising professional concerns that are not being taken forward. That goes along with Janet's point. We need to be listening to nurses who are raising concerns about circumstances in which they are working and have organisations take those concerns seriously.

Chair: You would like us to raise that with witnesses in the future. Thank you.

Sharon Allen: In addition to the parity issue that I raised throughout the session, it is important, whatever is decided will happen next, that we recognise the unique contribution and place of social care, and that we do not have a health and NHS approach that just tags social care on the end of it. We absolutely need to work together and we are part of a whole system. We are also quite different, and the different structures, opportunities and pressures need to be recognised.

Chair: That came across very powerfully from the House of Lords inquiry. We will be hearing further about that. Thank you very much for that point.

Daniel Mortimer: 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.

Q84 **Chair:** Do you think the fact that it is going to come to an end in two years is a deterrent to applying now, so having a longer timeframe would be helpful?

Daniel Mortimer: Yes, absolutely. It does not just facilitate recruitment but it helps people to stay. It is a way of bypassing the salary thresholds that are in place for people, which are much higher than what we pay

nurses, frankly. It protects us in recruitment but also in retention terms. It is acting as a deterrent, as you said, Chair.

Chair: Thank you all for coming today.