HOUSE OF COMMONS

Health Committee

Oral evidence: Nursing Workforce, HC 353

Tuesday 14 November 2017

Ordered by the House of Commons to be published on 14 November 2017.

Watch the meeting

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

Questions 85 - 177

Witnesses

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

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

Written evidence from witnesses:

- Professor Brian Webster-Henderson
- Jackie Smith
- Claire Johnston
- Avril Devaney

Examination of witnesses

Witnesses: Lord Willis of Knaresborough, Professor Brian Webster-Henderson and Jackie Smith.

Q85 **Chair:** Good afternoon and welcome to the Health Committee. Thank you very much for coming. For those following this inquiry into the nursing workforce from outside this room may I ask you to introduce yourselves, starting with you, Lord Willis?

Lord Willis of Knaresborough: I am Lord Willis of Knaresborough. I am a Liberal Democrat peer and co-author of the Shape of Caring.

Professor Brian Webster-Henderson: I am Brian Webster-Henderson. I am a professor of nursing and a mental health nurse by background. I am chair of the Council of Deans of Health.

Jackie Smith: I am Jackie Smith. I am chief executive and registrar of the Nursing and Midwifery Council.

Q86 **Chair:** Thank you very much. I will start the questioning by asking this of each of you. If you were planning the Government's forthcoming workforce strategy, what would you like to see included?

Lord Willis of Knaresborough: First, I think there does need to be a strategy. We must get away from this business of filling gaps whenever there is a problem with the workforce. We must decide, first, what we are trying to achieve. There is a clear move towards two significant changes. One is integration of health and adult social care. Therefore, I think the strategy has to include both of those. To simply do it for health without social care would be a gross mistake.

Secondly, we have traditionally built a workforce around silos of discipline and indeed of strata—either nurses, doctors or whatever. We have also built it around buildings. Indeed, in fact, it is buildings that cause us so many problems in trying to reconfigure our services. I think we have to say, are we going for a place-based future health care system? If we are, how do we integrate that into a strategy which delivers that for all parts of England, in this case?

Professor Brian Webster-Henderson: Coming from an education background, and to add to that, I would suggest that any workforce has to make sure that we are catering for the ongoing development of that workforce. A particular concern for members in our organisation would be around the training post registration to becoming a nurse. What does that strategy look like, and how does that education meet the needs of the caring environment for which it needs to cater? It is the changing shape of care and how can we make sure that people who have been in the system a long time are getting updated in education, knowledge and skills to help care for the community around them?

Q87 **Chair:** We heard very powerfully from nurses at the conference that I

visited last week that there was an imbalance in the system for allocating CPD money. Would you agree with that?

Professor Brian Webster-Henderson: Absolutely. I just cannot get my head round why we have up to around 60% cuts in CPD training for the current workforce. Almost like an obsession, on routes into the current profession for training graduates, that is absolutely vital. Catering for the needs of the current workforce is just as important, and it is an important retention issue for the workforce as well.

Chair: We are going to come on to retention in more detail. Jackie, do you have anything to say?

Jackie Smith: I would not disagree with what my colleagues have said. Our role is setting the standards for nursing and to make sure that they are future-proofed. We have just done a tremendous amount of work on that. You may wish to come back to that. Another area you may wish to come back to is our register and what that is showing. I will save that moment, if I can.

Q88 **Dr Williams:** The Government have laid an ambition for the UK to be self-sufficient in the supply of nursing within 10 years. Is that possible?

Jackie Smith: Perhaps I can start with the register. We published some data in July. We published it again last week. It shows that UK graduates are leaving the profession. It paints a pretty bleak picture in respect of Europe. That tells us that there is a problem. I think we can focus on routes in, but how are we retaining the workforce?

Lord Willis of Knaresborough: I do not think it is possible. I think that timescale would make it very difficult indeed to deliver particularly the quality of workforce that you need. With the nursing workforce in particular, now that we have moved to a graduate workforce from 2013, we are starting to recognise that a graduate workforce is in fact different from a non-graduate workforce, and that we require different things of those colleagues. They have to work to a different level and different standards. There are different expectations and I think that is right and proper.

We have a real problem here, particularly with overseas recruitment. We have treated our nursing workforce very much as a commodity. We have treated it as a commodity because, when there have been shortages, we have been able to buy in from elsewhere. Forgetting the EU situation, that is the wrong thing to do. We have brought people in either from the EU or sometimes from developing countries. Quite frankly, that has been shameful.

What we need to do is to turn that on its head. I think we can recruit from abroad in very significant numbers provided, as part of the overall strategy, we actually look to our strengths. Traditionally over the last 150 years we have brought people in from abroad, trained them and returned them to their countries to develop onwards. Provided we are the leaders

in international recruitment and, indeed, have that process of developing and then returning, we will be able to plug a very significant gap. Rather than it being a commodity it would be a contribution to world nursing, and indeed to world health. I think that is important.

The other thing is if we require a workforce, particularly a graduate nursing workforce. My colleagues have talked about the obsession with routes; and I am obsessed with routes in. I think the focus on where we get our workforce from is too narrow. I am very much of the mind that we need to expand the way we bring people in at all levels, and indeed of all ages, into this workforce. We must not have a glass ceiling in terms of where we get that workforce from.

Having said both those things, I think 10 years to produce a workforce that is entirely UK based in terms of its origin is not possible.

Professor Brian Webster-Henderson: There are a couple of other issues that I am not sure we are hearing loud enough. There are issues around placement capacity. If you are going to educate student nurses, you can only do that if the placement capacity is there to give them the rounded experience they need to meet the standards to get on the register and help them understand what careers in healthcare might look like and to want to stay in it.

We can say that we have numbers we want to achieve and look at that, but, if we do not resource the issues to support our colleagues in practice and look at placement capacity, then there is going to be a cap on what we can do.

Lord Willis of Knaresborough: I slightly disagree with Brian—I am loth to do so, and I always have been. I think we are looking at this placement capacity, again, through a traditional lens. The traditional lens is that they go through a graduate programme, which is higher education institution- based, and they do their 50% and then a placement elsewhere. They are then mentored on a one-to-one basis. If that model continues, Brian is absolutely right: we cannot deliver that. There needs to be a root and branch change of how we do that.

Norwich and Norfolk trust—a very large East Anglian trust—has developed a method of dealing with a very significant number of placements in the same place. For instance, I have witnessed 20 students in a coronary intensive care ward working on a mentoring system with each other, and indeed using the whole of that professional workforce to mentor the students. That is from the senior consultants and the senior surgeons right through to healthcare assistants who are particularly trained in key areas.

We have to look at that model of doing things differently if we are going to get the quality placements into the workforce.

Q89 **Dr Williams:** Jackie, in your answer you talked about the data you have released. We certainly know that the data show that many more nurses are leaving the register than are joining. It is coming across loud and clear that retention is a key feature. In your view, why are more people leaving than joining?

Jackie Smith: I can only really talk about two things. One is my experience of going around the UK, but we are obviously talking about an England issue here. The other is the small survey that we did in July. The 4,500 who responded said that the issue for them was working conditions.

That can encompass a lot of things. That is about staffing levels; about flexibility; about pay; and about not investing in their future. Cuts to CPD are a major issue. That is what I hear when I go around the UK. The nursing profession does not feel valued. What it does is not recognised sufficiently. For them they think, "I may as well go elsewhere and do something else." That is tragic. That is not what we need.

Q90 **Dr Williams:** That is something general that came across in the survey. Do you have any information from nurses who have come from EU countries about why the rate of EU nurses leaving is increasing and why so few people are registering?

Jackie Smith: Again, the small survey that we did included a couple of hundred EU nurses. Some said that they had already prepared to go back to their home countries. Some said that it was about Brexit. Some said it was about working conditions.

There is an issue in respect of language testing. We introduced that last July, a week after the vote to leave Europe. The timing was impeccable. That saw a dramatic fall. Language testing, I have no doubt, is a factor, but if you look at the number of European nurses leaving the register that has nothing to do with language testing. That is to do with a variety of issues to which I have just referred.

Q91 **Dr Williams:** Are there any other insights around retention or why so many people are leaving?

Professor Brian Webster-Henderson: Certainly from the education sector we hear our students, both undergraduate out on placement and for post-graduate programmes or skills-based CPD programmes that lots of universities run. We have seen a huge decline in numbers because of release issues due to staffing pressures in the clinical environments—it is difficult for them. We have tried to be really flexible as a sector. We have some great examples of where universities have moved a lot of the provision to weekends, evenings and online-based programmes.

As a registered nurse there is only so much you can learn online. There are some skill bases that you would have to learn within a practice environment. We have great examples across the UK, particularly in

Scotland, of online programmes for students, but the funding is not stable. It has been decreased. As a nurse, personally, that would make me feel devalued as a registrant and as a member of an organisation.

Q92 **Dr Williams:** The messages that are being sent, or that people are hearing, are that they are not valued. That is the overwhelming message, but it is for a number of different reasons.

Professor Brian Webster-Henderson: Complex reasons.

Q93 **Dr Williams:** Including, from what I am hearing, the investment in their continuing development and education. The message from leaving the European Union might partly also be that people are not valued as well. Do people feel an uncertainty about their future?

Jackie Smith: Again, anecdotally, the uncertainty is a factor, but it is a combination of factors.

Lord Willis of Knaresborough: I echo entirely what my colleagues have said. Pay is obviously an issue. Flexibility is an issue. Lack of a clear framework is an issue. A major problem is the fact that after a nurse has graduated they are looking ahead, and it is very opaque. It is a matter of serendipity as to where you arrive before you go forward.

This issue of trust and autonomy is fundamental to professional people. We have to treat our nurses as professionals. I have with me today Rebecca Graystone, the director of the Magnet programme in the United States, which is the largest quality nursing programme that you will find in the world, and certainly in the US. When I went to look at Magnet in the States—and we have the senior nursing colleagues from Nottingham as well here, which is going to be the first Magnet hospital in Britain to achieve the standard—I thought this would be something very complex. These are a set of hospitals, about 7% in the United States, that have the lowest levels of attrition and the highest outcomes in virtually all disciplines. They are not in the fanciest buildings; they don't get paid particularly well. So, what is it? When you look at it, it is really about the autonomy of nursing staff. It is about being able to lead, to be in charge of what they do and to work as teams.

We have stopped doing that and we need to get back to it. A cultural shift is needed if we are to give nurses the respect they need. From that respect, they will build up the trust within organisations to deliver high-quality care. At the moment that is missing.

Chair: Welcome to all your colleagues from Magnet who are visiting today.

Q94 **Dr Cameron:** Thank you for what you have said so far. It paints a picture of nurses struggling on the wards and in the community and of continuing professional development. Are they raising concerns regarding how this impacts upon safety? Are we stretching them to the hilt?

Jackie Smith: That is quite a difficult question to answer. I know the RCN published a survey not so long ago about the fact that nurses were raising concerns about staffing levels. That is obviously a feature in working conditions. I do not think we have any data to suggest that we could tell you that safety was an issue.

Q95 **Dr Cameron:** Is that something your members are raising? Is it a concern for them in terms of the situation they have been placed in? Having to do CPD at night-time after doing a long shift seems—

Jackie Smith: Yes. There is absolutely no doubt that the nursing profession feels under tremendous pressure. Demands are great. Expectations are extraordinarily high. As we have said, they do not feel valued. They do not feel invested in. They feel under pressure. As a regulator, we do not have information that I could point to that would help with that answer, I am afraid.

Professor Brian Webster-Henderson: To be positive, I would agree with all that Jackie Smith has said there, but the manifestation of this is longer waiting times, particularly for operations. You are seeing longer waiting times at A&E. That is because the nursing workforce continue to put patients first, in wanting to give them a quality outcome. If it takes longer because we are pressed for time and for colleagues, then that is what it has to be. I do think we are far better going for safety first rather than meeting targets, which somebody sets arbitrarily in order to push forward.

Q96 **Chair:** One of the delegates at the Nursing Times conference last week said very powerfully to me that she goes to work every day worrying that her pin number is at risk. Is that something that you are hearing?

Jackie Smith: Yes; we do hear that. What they say as registrants—and they have a code to which they must adhere—is, "I need to raise concerns." It is very clear that they do. Our fitness to practise data are not showing an increase in the number of complaints that we are getting. They are not showing a shift in the nature of those complaints. There is not the evidence to back it up, but there is a lot of anecdote and a lot of feeling around this issue.

Q97 **Dr Caroline Johnson:** I want to ask some questions about the language testing that you mentioned earlier on. We know that communication with patients is one of the most important aspects of care in understanding what is wrong with the patient and the patient understanding what treatment they might need. What benefit do you think that the recent changes to language testing will have?

Jackie Smith: There are two aspects to the changes that will probably make a difference. Certainly, the early indications are that we are seeing an increasing number of applicants expressing an interest. The first is that we are offering an alternative to the current test. The occupational

English test provides that clinical context, which I think a lot of applicants taking the IELTS felt was not present.

The second aspect is evidence of studying and practising in English, which for applicants coming from some countries will be easier to provide and they will therefore not need to take the test.

We would not have proposed these changes if we did not believe it would make a difference. We have been very clear with employers that we need to understand where they are going to in terms of recruitment so that we can respond to that.

As I say, early indications are that a significant number have registered to take an alternative test or provide evidence of studying and practising in English.

Q98 **Dr Caroline Johnson:** Do you think that will increase the number of people from abroad who apply to do nursing? Do you think the new tests are going to be easier or more difficult to pass? Do you think they are going to provide the same rigour so that patients still get the same quality of service?

Jackie Smith: One of the things about which we have been absolutely crystal clear is that in response to a workforce crisis it is wrong to lower standards. We have not lowered our standards. We have been very clear about that. We must not compromise patient safety and public protection in the light of this crisis, but we need to respond to the concerns that have been raised, which is what we have done.

It is an alternative test, but it is the same score. If you can provide evidence of studying and practising in English, that will satisfy us that you can practise safely here, providing we have the right sort of documentation to support it.

Q99 **Dr Caroline Johnson:** So you do not think it is having a negative effect on the number of people coming here.

Jackie Smith: I do not think so at the moment. It is early days. It is only 13 days into the new arrangements, but early indications are that we are seeing a significant number registering to apply to take it.

Q100 **Dr Caroline Johnson:** The other question I had was about the new types of nursing role about which we heard a lot last week—the nurse associate and advanced nurse practitioners. What position do you take on the regulation? We know that nurses and doctors are regulated, but the new roles are not specifically regulated. What are your plans in that regard?

Jackie Smith: I will talk about nursing associates first. Phil might want to give the history and the background of the role. We were asked at the beginning of this year by the Secretary of State whether we would

become the regulator. Our council agreed to do that. It is an England-only piece of legislation, and we are a four-country regulator.

The difficulty is that we are having to regulate a workforce without there being any legislation in place. We are doing everything in reverse order. To try to help the trainees, we have issued a working draft of the standards that we think they might need to meet to join the register. Obviously, we will need to be clear about the code and the registration fee. We are having to do all that in the wrong order because of where we are. We have worked very closely with Health Education England and the pilot sites to support the trainees, because that must be the right thing to do.

Advanced nurse practice has been around for a long time. There is a debate that frequently goes on about whether we should regulate advanced practice. The council's position on this is that we should have a debate about it. We need to start with the patient safety issue in relation to advanced practice. What are we trying to achieve, and what do we mean by "advanced practice"? If we can understand those issues we might get to a place that allows us at least to answer some of those difficult questions about advanced nurse practice.

Professor Brian Webster-Henderson: In the higher education sector, we currently have around 43 universities that are running nursing associate programmes. We understand the need to be flexible in the workforce, and therefore the higher education sector is responding accordingly. We are working closely with partners and colleagues across the NHS to provide a good-quality education.

Our view and worry would be that we do not see the nursing associate role at the expense of the graduate nurse. We see them as an individual member of the workforce in their own right. Some of them may choose—I emphasise the words "may choose"—to use that qualification to move into becoming a registered nurse and do further training. It is a long way to do it, but some of them may choose to do that. As a sector, we are open to that.

Many of our universities run post-graduate programmes in advanced practice. They are a good, high-quality education. There are no set standards for that, so we work with our local healthcare providers to ensure that we can try to flex the content of that programme to meet the needs of their workforce, but I guess it is an issue.

Q101 **Dr Caroline Johnson:** Do you think that advanced practice is now quite well established, that there are many more advanced practitioners than there were when, say, I qualified in 2001, and that the time has come to make sure that there are some standards that they meet? If patients meet a practitioner in one hospital and then move to a different area and meet a practitioner of the same title in another hospital, should they know that those people have equivalent skills?

Professor Brian Webster-Henderson: I guess there is a baseline of knowledge and skills. At every university, clinical assessment, history taken, physical assessment and decision making should be part of those advanced practice skills.

There is a bit of an issue with language. An advanced practitioner in an acute hospital might be very different from an advanced practitioner in mental health, where the skills might be more psychosocial or CBT-oriented, solution focused or whatever the skill is. Advanced practice is in danger of being seen as an acute hospital-based role. Advanced practice can go across a range of professions but needs to relate to the skills and needs of that profession.

Q102 **Dr Caroline Johnson:** I was meaning more that if I am a junior doctor and I move, as they do, from trust to trust every six months and from ward to ward, and I meet a nurse practitioner on one ward, it is perhaps natural to assume that if they carry the same title as the nurse practitioner on a ward I worked in before they can do the same tasks. My clinical practice has found that actually that is often not the case, and some nurses in some areas are doing great work but cannot do something I expected them to do because they have not done it and that is not how they are trained in that trust. Even within the same trust you might find—for example, in an emergency department—that some of the nurse practitioners are trained to a higher advanced level and, despite wearing the same badge, can see patients with conditions that others cannot. If there was standardisation it would be clearer, both to patients and to other staff, what each member of staff could do.

Jackie Smith: I think this is quite a complex area because the regulator finds itself in the territory of policing what employers do. There is a fundamental issue around the use of titles. "Registered nurse" is a protected title, but "nurse" is not. You will know that recently a piece of work was done on how employers are recruiting nurses and describing them as advanced nurse practitioners when they are not even regulated. That is a patient safety issue. We should not mislead the public. We should be really clear. This is a nurse who is regulated by the NMC.

I think what you are describing is actually quite difficult. It is hard to regulate bits of practice. You need to understand the scope of practice and then set the right standards, which is where we come in. We have set standards that really do future-proof nursing, not just for the next five or 10 years but for 20 years. That is the place we need to be in. How employers use nurses is a slightly different issue.

Chair: We are going to come on in more detail to skill and skill mix, but before we move off the area of workforce strategy I know that Luciana wanted to come in.

Q103 **Luciana Berger:** This is on the international Brexit element. My colleague Ben unfortunately had to go to the Chamber because the Bill has just commenced. He asked a question at Health questions this

morning of the Secretary of State in relation to evidence we heard at a previous session about concerns on Brexit. In his response, the Secretary of State told us that he seeks to reassure the workforce at every available opportunity that they are valued. To what extent do you believe that the workforce hears that message? Does that resound with them? Will you speak in a bit more detail about what impact you believe Brexit is having on the workforce, and in particular on the numbers?

Jackie Smith: I take it you are leaving that one to me.

Lord Willis of Knaresborough: It is very difficult for us to answer that other than anecdotally. I visit hospitals weekly, and there is no doubt that when you speak to EU nurses they do feel that uncertainty. They hear all the language and they hear all the messages, but until there is a piece of paper that says, "I have the right to remain and continue to practise" there will always be that doubt in their minds.

My biggest worry, if I am honest with you, is that when you look around the western world, and particularly at the United States, the United States is trying to recruit a million graduate registered nurses to prop up its workforce. English-speaking nurses coming from Spain, Portugal or elsewhere have a real opportunity to move to somewhere where not only do they feel wanted but they actually have longevity in terms of a green card.

We have competition in this area and we need to sort it out to make sure that people have the continuity that they want and that our patients want.

Professor Brian Webster-Henderson: As a higher education sector, it is fair to say that we do not see very many European pre-registration undergraduate student nurses. They predominantly come from the UK or the local surrounding area. That is the typical pattern. As a sector I would say that I am worried around staff who might be European nationals and the impact it could have on the staffing of universities. We get students from other areas, other subjects, and there is a research concern around research funding. There are implications that absolutely need to be resolved.

Jackie Smith: From our perspective, the European bit of our register is only 5% of its overall size: 85% comes from the UK and 10% comes from the rest of the world. The numbers are relatively small, but none the less in recent years they have been making up the difference because they have been coming from Europe in their thousands and now they face some uncertainty. That uncertainty is obviously making them question whether they want to stay. Again, that is purely anecdotal. We do not have any evidence to back that up.

Q104 **Andrew Selous:** We have some data from the NMC—a bar chart showing the split between EU and non-EU nurse registrants going back to 1990. What jumped out at me was the very large numbers of non-EU

nurse registrants from 1998 to 2006. There were five years in the middle where it looks as if we recruited 15,000, 13,000, 14,000, 12,000 and 9,000 non-EU nurses a year. They are really significant numbers.

It is a tail-off of those entrants coming in rather than a decline in the EU that interests me. I would be interested in your take on the position of non-EU entrants into the profession. What are the possibilities, and how could we take advantage of them?

Jackie Smith: Traditionally, of course, we go to countries such as the Philippines and India—the two main countries outside Europe where big numbers come here. Those are the countries where you saw the big spike. That has tailed off quite significantly in recent years.

Q105 **Andrew Selous:** Is there any reason why? Could we not get it back up to meet the shortages you have all been telling us about?

Jackie Smith: I suspect it is possible for employers to do that. I suspect they can very easily go to those countries.

Q106 **Andrew Selous:** Would it not be necessary as well as possible?

Jackie Smith: I suspect it is absolutely essential—they will need to strategically internationally recruit. It takes a long time to train a UK graduate. If Europeans are not coming here or are leaving, we need to find them from somewhere else. It would make sense to go internationally.

Q107 **Andrew Selous:** Have you seen any enlightened hospitals or employers that are leading the way, from which others could learn?

Jackie Smith: What we have been asking for all year on the back of the challenges around language testing is, "Where are you going? Please share your plans with us," so that we can respond accordingly.

Lord Willis of Knaresborough: Andrew, you raise an important issue in the recruitment of overseas nurses, whether it is EU or non-EU. There is a considerable cost attached to going out to the Philippines and setting up a programme to bring people back, and then to assimilate them into your workforce. If individual trusts do that up and down the country, they duplicate effort. There does seem to be an opportunity to get our house in order and to ask what UK plc or England plc is doing to make that a smooth transition. That is very effective.

Last week I was in the Royal Marsden looking at robotic surgery. Of the nurses who were working in that theatre, three were Filipinos and one was from Singapore. The issue they talked to me about was the lack of CPD and career progression, having got here. These issues all tie in together. They are not separate.

Q108 **Dr Cameron:** Do you believe we have the correct mix of skills for those we are training to provide the nursing workforce of the future that we need? Is it the correct skills mix in terms of our workforce plan?

Lord Willis of Knaresborough: Absolutely not. That is the truth of that. First, you have to identify what skills we need. As I said when I was here a couple of weeks ago, we are notorious at looking back and filling in the things that we should have done but which we have not. We now have an opportunity to look forward.

I will give you one example, and the medics around the table will tell me I am talking nonsense. Within five years, I suspect that genomics and genomic medicine will be a significant player within our health service and there will be an increase in personalised medicine. I am looking at the university curriculum. The nursing curriculum does not feature at all virtually. It is the same with medical careers; that is the reality. That is just one area of skills that could dominate. Are we bringing forward the people who have the bioinformatic skills and the computing skills to be able to deliver that?

We are talking about moving into a far more closely related health and social care environment. Where are we developing those integrated skill sets to enable us to do it? We are still training nurses in the four branches. The need to be able to cross over those branches is really important. There is significant work to do here and I do think that the workforce is quite willing to change their skills, to upskill and change patterns of work, but we really have to make it worth while for them and there has to be investment in it—back we come to CPD and the rest of it.

Jackie Smith: I will slightly disagree with Lord Willis, if that is allowed. The work we have done recently on future nurse standards deals with many of the issues that Phil has raised. If we do not set standards for the future, we are always going to be playing catch-up. It takes us a long time to get to that position. It is not quick; it is not easy to change standards.

You mentioned genomics. That is in the future nurse standards. There are new technologies. This is precisely where we are meant to be, and we have to bring together physical and mental health as part of the same care conversation.

You are right that we do have four branches, but what we are saying is let us think about this holistically because it is not just in buildings that nursing care is delivered. It is in the community and in a whole range of settings. We have to be flexible about the standards we set.

Professor Brian Webster-Henderson: The NMC has done a fantastic job on the consultation of the new standards from all sorts of stakeholders. As a higher education sector, I think we are more than ready and well prepared to work towards these standards for the future workforce.

We have had a number of earlier doctors and people signifying that they want to go and get the programmes validated and work to new standards. From the graduate nurse perspective, the skills of the

graduate nurse for the future have been well rehearsed and well documented. They now just need to be executed.

Q109 **Dr Cameron:** Will changes to the education system be required to facilitate the needs of the workforce?

Professor Brian Webster-Henderson: The education will have to be tailored to the needs of that workforce. The new standards are challenging in the sense that we do not know how to do them. But we do; we have skills and we are attracting lots of roles that work across both education and practice. There is a whole different way that we can deliver that as a higher education sector. I think we are in a good place to do that. We have had a very good consultation with the NMC and with practice colleagues. There is still a bit of work to do.

Q110 **Dr Cameron:** The thing that strikes me is that, in retaining people, those who are already trained need CPD and skilling. Is there going to be provision for that?

Professor Brian Webster-Henderson: That hits the nail on the head. That is what I am saying; I cannot get my head round why we have had a 60% cut to CPD requirements at a time when we are introducing new standards. This is not the time to be cutting CPD funding. This is the time to be investing in the workforce to make sure that they also come up to those standards. It is just a nonsense, really.

Lord Willis of Knaresborough: If you look at one area—nurse prescribing—clearly the NMC has done quite a remarkable job in getting an outside body, the Royal College, to come in with standards that can be uniform across a number of different settings. One of the big barriers in community care and community nursing is that so many of our nurses do not have that badge that says they can be nurse prescribers. The new standards will allow that to move forward seamlessly. The universities are, quite frankly, doing a good job in picking up a very difficult baton and running with it.

Q111 **Maggie Throup:** We have already touched on the subject of nursing associates. Lord Willis, the recommendations of the review that you chaired, the Shape of Caring, talked about the role of nursing associates. Are you happy with the way it is moving forward? What would your thoughts be now on that?

Lord Willis of Knaresborough: When I made the recommendations in the Shape of Caring I did not talk about nursing associates. I could not think of a title, if I am honest, because I knew whatever was put down would be contentious.

I saw four things. First, it was a bridge between the unregulated and the regulated workforce now that we had a graduate workforce. Secondly, it was to support registered nurses so that they could delegate safely to someone who had the skills and who they knew would have the skills to do that. Thirdly, it was a career post particularly for healthcare assistants

and care assistants. Lastly, it was a prelude to integrated health and social care. That is how I envisaged the nursing associate's role playing out.

When it was recommended and we were talking to the NMC about regulating it, the chief executive said, "I will wait for a call from the Secretary of State." Nevertheless, without those conversations with the NMC it would have been difficult to have pulled that role off.

Would I have liked it to have gone slower? Probably. Would I have liked it to have been a little more complete before we started to move to the regulatory phase? I think the answer to that is probably yes. Equally, I know it would not have happened, because unless you start on a journey there is always a reason why you do not do it.

Brian mentioned the number of higher education institutions and trusts that are involved with nursing associate work. It is an iterative process. Yes, there is an overall curriculum. Yes, we have assessors and we are looking at making sure that it is quality assured. But this is not to be written in tablets of stone. This is to be the way in which a healthcare system will develop in future and where a workforce will develop. Just as the nursing standards are now flexible, to accommodate new ventures, hopefully the nursing assistant standards will equally be flexible. If that is achieved, I will be a very happy man as I go into my care home.

Q112 **Maggie Throup:** Will they be called "Willis nursing associates"? Some nurses have expressed concern about what they are expected to do with regard to the training and supervision of nursing associates. We have touched on the regulatory framework, but how can those concerns be alleviated or what is being done to alleviate the concerns?

Jackie Smith: There is absolutely no doubt that nursing associates divides the profession. There is a great deal of feeling about the role. There are those who remember the old enrolled nurse and how they were treated. The difference here, as Phil has said, is that there is that career pathway. If you want to become a registered nurse, you can.

The reality is that nursing associates are here to stay. They are a fact. We need to make sure that we set the right standards so that they can practise safely and they are supported.

I absolutely understand the graduate workforce feeling devalued and undermined, because what they are doing, and what we all need them to do, is not fully appreciated. Our role is to make sure that the standards are as clear as they can be; that the trainees are supported; and that the expectations when they join the register are absolutely clear.

We are only talking about 2,000 nursing associates. There are 640,000 nurses. The numbers are tiny, but the issue is still quite controversial—for very good reasons. The narrative around this must be really clear.

Lord Willis of Knaresborough: It is not a substitution; that is the key point. It must not be. If it is used as a substitution, then, quite frankly, a lot of work that we have done over the last two or three years will have been to little avail.

Professor Brian Webster-Henderson: That would have been my point. It absolutely cannot be a substitute for the graduate nurse. It has to be a helpful contribution to the workforce in its own right. Jackie said earlier that everything has been done back to front. I absolutely echo that. It is a really odd way to do this. It is in danger of becoming a bit knee-jerk unless it is controlled and strategically thought through in a plan around what we need.

The members I represent are the 85 universities across the UK. Of course, this is an England-only issue. In the future, that could cause issues when people start to move across countries and they are on a register but they cannot practise in another country because they do not have them. That has not really been thought through. Our workforce has had some professional concerns, which we have worked through with them. The higher education sector has demonstrated its ability to be flexible to the needs of the workforce and work with partners and the regulators to create standards that we think will be right for the future.

Jackie Smith: The idea that the graduate nurse would disappear is not only unthinkable but is, frankly, dangerous. We need them. They are absolutely vital and we need them to be practising at a high standard. We are all absolutely behind the graduate workforce. It is essential.

Q113 **Maggie Throup:** That is a really strong message, which is fantastic. Jackie, you just mentioned that we used to have SENs and SRNs. I remember those days as well. We have also talked already about genomic medicine and the way that is going, and Lord Willis's passion for having the generic skills out there that are going to be so important for the future.

Have we still got it right? We have graduate nursing and nursing associates. Do we need anything else? Do we still have gaps that we need to fill with regard to the skill levels?

Jackie Smith: I am passing that question to Lord Willis, if I may. I think that is quite difficult. If we look at the complexity of care and what we are expecting healthcare professionals to deliver, it is very difficult to ask, "Have we got it right?" The time it takes to train professionals and the speed with which we need them to be up to date and moving with the latest technology is extremely demanding. We need to be creative and innovative, but we have to retain the existing workforce.

We can worry about routes in, quite rightly, but what are we actually doing to retain a really highly skilled workforce that we all need?

Lord Willis of Knaresborough: When Robert Francis made his really quite condemning report on Mid Staffs, he highlighted the fact that so many unqualified and untrained care and nursing assistants were working within the system—1.3 million in total. Over the last five years we have seen the introduction of the care certificate. I would have liked that to have been mandatory. That is what I said in the report. Fifteen thousand people got the basic care certificate last year. When Camilla Cavendish did her report and followed that on, there was a recommendation that there should then be a high-level care assistant, which would then lead on—which was my thought—to the associate nurse, so there is a proper career pathway.

More importantly, we were actually training people at every stage so that the workforce was becoming better qualified, better trained and more aspirational right the way through. Virtually all the 2,000 nursing associates have come from healthcare assistant backgrounds. I think that is quite fantastic.

Q114 **Chair:** One of the concerns we have heard is about nursing associates being asked to do things for which they are not trained. Will you, Jackie, set out clear guidance for them on what the limits are?

Jackie Smith: Yes. There has to be clear blue water between the registered nurse and a nursing associate. We have issued the first working draft of the standards—what we expect the nursing associate to be able to do at the point of registration. That is allowing trainees to work with something as they go through their training. We will come back to that when the legislation is in place.

Q115 **Chair:** There will be guidance about what you are expecting them to work towards as well as saying, "This is not a role that you should be expected to do as a nursing assistant."

Jackie Smith: Yes; we will set the standards of proficiency. We will set out what we think the skills are of a nursing associate.

Q116 **Chair:** But will you also be setting out some protections so that they are not expected to practise beyond their skills? That has been expressed to this Committee.

Jackie Smith: We do not set standards by saying, "You can't do this." We set standards by saying, "You must do this at the point of registration. You must be able to demonstrate your knowledge and skills in these areas at the point of registration."

Q117 **Chair:** I understand the rationale for that, but one of the concerns that has been expressed to us is that nursing associates may be pushed—perhaps because of pressure on wards—to operate beyond that. How are you intending to make sure that that does not happen so that we can protect patients and the workforce?

Jackie Smith: The only way in which we can do that is by setting the standards that we are right now. It is in effect the same argument with the graduate nursing workforce and advanced practice. The debate is, are they doing the work that junior doctors used to do? Our role is to make sure that we are very clear about the standards and the skill set that is required. We have to rely on employers to be able to understand that and police it appropriately.

Q118 **Chair:** Are you happy with the level of follow-up research that is being done around safety issues, around having a new workforce?

Jackie Smith: I find that quite a difficult question. Of course, the Government asked Health Education England to do the Shape of Caring, which was the genesis for this role. There is plenty of research and evidence on the value that a graduate nurse provides in respect of mortality rates. I do not think I am in a position to say in relation to nursing associates.

Lord Willis of Knaresborough: The nursing associate role is not new in international terms. Probably the best piece of work to look at is Lord Crisp's recent work on global nursing. You will see that in large swathes of the country, in the States and certainly across Europe, you have the equivalent of nursing associate roles, but they are regulated roles. Once you have a regulated role, a colleague can then say, "I am not competent to do that work."

One of the problems that Francis saw was that healthcare assistants were being asked to do all sorts of things that they were not even remotely trained to do within that workforce. That was fundamentally wrong.

Chair: Thank you very much for setting that out clearly.

Q119 **Luciana Berger:** You have already touched quite a lot on issues around retention. I want to ask you a little more about it because it is the feature of a lot of the evidence we have received.

Lord Willis, in your evidence you diagnosed the loss of nurses in the three to five years following their training as a case of, in your words, the "leaky bucket syndrome." You said it was particularly because we are not looking after them. Would you like to embellish that a little to explain what you mean by that, and what you think specifically and most practically can be done to prevent it?

Lord Willis of Knaresborough: There are two things. One of the things that I found really difficult—I visited 168 settings during the work on the Shape of Caring—and frequently came across, talking to first year staff nurses was that they were expected, once they had got their badge from the NMC and their degree, to be fully fit to do anything that was asked of them wherever they went. In other words, they were a complete article. They clearly were not, but there was this idea that you begin your

professional work once you have qualified, moving forward. The feeling was that they were not getting supported at that stage.

I thought that was really quite shocking, quite frankly, and it was why I recommended a two-plus-two model. The preceptorship model was a full year during which they were getting support, not the patchy framework we have at the moment. Preceptorship, quite frankly, needs to be looked at seriously in terms of supporting.

All of you who have qualified will know that the first year in any job is very traumatic, but when you are working on a ward—in one case, in a children's ward where children were on the cusp of death daily—feeling that you just did not have the skill set to be able to deal with that despite your training, that is when you need the support. There was a real feeling that we did not have that in place. You would do it with a good preceptorship year, where there are proper procedures in place to support the nursing staff.

It comes back again to the CPD issue. I wanted that year post graduation as part of their professional training, so that you actually put support in. It had to be support from the employer during that year to make sure that that happened. It is really quite simple.

I always use the Waitrose and the John Lewis model here. Their staff retention is quite brilliant. In the first few weeks and months after they have joined the company they are looked after and mentored. They are valued throughout that time. That is what we get wrong. It is not big bucks. It is not a revolution. It is really about employers making sure that they care for their workforce. If you do not care for your nursing workforce, how on earth do we expect them to deliver the quality of care that they are expected to deliver?

Q120 **Luciana Berger:** Indeed. The evidence we received from the *Nursing Times* showed that the main reason for nurses leaving, or one of them, was the lack of training and development. They also talked about nurses being unable to provide the standard of care they joined the profession to offer. It was both the standard of care we are giving to them in terms of their training but also the standard of care—

Lord Willis of Knaresborough: I frequently came across the difference between when they had been on the placement with their university and then the reality of what it was like when they actually got on the ward without that support. All of us know that there is an ideal that quite often is very difficult to live up to. I remember when I first came into parliament as a young MP at 55. It was very difficult to actually do what was expected of me at that time without the support mechanisms.

I found it really sad that people we expect to be at the heartbeat of the caring system were not cared for themselves. It is not just about not having the skills to do certain things. Often, they did not have anyone to

go to who could support them at that stage because it would be seen as a weakness.

Q121 **Luciana Berger:** In its evidence to us, NHS Improvements provided an account of its work to improve retention in a number of specific trusts. Will you reflect on its work and tell us whether you think it is having an impact? If not, what needs to be done?

Lord Willis of Knaresborough: I hate to spare their blushes, but with me today are colleagues from Nottingham University trust. Their retention scenario is quite phenomenal. They have put in place systems to look after colleagues—workforce committees and ward committees, and giving responsibility for the ward to the people who actually work on it. That is the sort of thing that Magnet brings in. You put people in charge and give them the authority and autonomy to solve problems. They can go to each other for doing that, rather than a culture that says, "If I can't do this, I will just have to get on with it."

Q122 **Luciana Berger:** You have touched on the cuts to funding for CPD quite a few times, but it is worth finishing on that because it is an important area. As you rightly point out, and I did the sums myself, it is just under a 60% cut today from what was available two years ago. Yet in the joint submission that we received from Health Education England, the Department of Health, NHS Improvement and NHS England there is not one single mention of CPD for nurses. Do you think those organisations do not value CPD? What could and should be done to make a difference?

Jackie Smith: I will try to avoid directly answering that, but I will just talk about CPD from the regulator's perspective. Of course, we have done our own narrow bit in respect of CPD through revalidation. When we introduced revalidation, the expectation was that nurses and midwives would leave the register in droves. Actually, what has happened is the reverse. They value CPD. They value reflecting on their practice. They value thinking about the standards set out in the code. Ninety-four per cent of the register has revalidated in the last 18 months. That is the importance of practice and CPD from our narrow perspective.

As to why those organisations did not comment on it, I would be speculating.

Q123 **Luciana Berger:** Does anyone else want to answer that one?

Professor Brian Webster-Henderson: I find it surprising that they did not. As a nurse—I am a mental health and an adult nurse—I have had a long career in practice and I have moved around from different areas. It would be absolutely wrong to think, if I worked in a medical unit for a year and then moved to a surgical unit, that I would have the exact skills that I needed to care for those clients. I would have transferable skills, but I would need investment in a specialist area. You would not expect a newly qualified nurse to go and work in a burns unit without having some advanced practice skills or advanced education in burns. It just does not

make sense why organisations would not comment on CPD when actually it is one of the most important things we need for the profession.

Q124 **Dr Caroline Johnson:** I just want to bring up one of the points you made, Lord Willis. You talked about John Lewis and Waitrose, and you felt that their retention was down to having a preceptorship in the first year. My experience is that they incentivise people to stay with them by making them shareholders of the company.

I was horrified by one of the things you said about children's wards and junior nurses. As you may know, I am a consultant paediatrician and have seen far too many sick children at the point of near death in the last 15 to 20 years. But at no time do I remember seeing a junior nurse left alone unsupported with a sick child of that degree. It is usual when a child is at the point that they are so ill that they may die in the next few minutes or hours that they are actually surrounded by many members of staff: doctors and nurses. There may be 10 or 20 people in the room trying to save their life. I do not ever recall seeing a junior nurse left alone to manage such a child. I am horrified to hear that you think that is widespread practice. I have never seen it in all the years I have practised and on all the different wards I have worked on. I am wondering whether you have found it to be widespread or an isolated feature.

Lord Willis of Knaresborough: No. This was certainly an isolated case. It referred particularly to mental health issues. It was because of the problems that resulted from the long illness and then the death of a child that this particular nurse felt totally unprepared to deal with the mental health issues, which arose as a result of that. I questioned her about the training she had received. She had received virtually no training in mental health. That was missing. She had to go and seek out support for that. I suspect that for her that was very traumatic indeed.

Q125 **Dr Caroline Johnson:** I am sure it was, but I think it is wrong to present an isolated case as being reflective of the whole of the paediatric service.

Lord Willis of Knaresborough: I think the evidence will show that I did not do that.

Q126 **Chair:** May I take it that you are reflecting on the stress that is placed on nurses who are dealing with those situations?

Lord Willis of Knaresborough: Yes; that is right. It is not individually, no.

Q127 **Diana Johnson:** I would like to look at student funding reforms, which have come into play. What are your views on what has happened so far with the new funding regime?

Professor Brian Webster-Henderson: I had better start with that one. It is fair to say that we are only a year in, so it would be quite early to make some concrete assessment. It would be fair to say that the Council

of Deans did support the move to a different form of funding for several reasons that I think are really important.

One was that the commissioned approach created some of the boom and bust with nursing. You would have a commissioned number as a university, which then meant that you could be turning good applicants away or you could be putting them on a waiting list for the following year. There were issues around how you planned your higher education workforce based on income that comes from set targets that could rise or drop, depending on the commissioner's perspective and what the need was. That was definitely one of the issues.

Another issue that we were beginning to see, through the old system of reform, was a marked difference between the benchmark price as it was then—the system for funding—and the funding it took to train a nurse. HEFCE has just done a recent study into the cost of delivering high-care courses such as nursing and medicine.

The third issue was around the students themselves. In the old bursary system students would quite often have to have part-time jobs—along with working in practice, along with studying—to help with support, because the bursary was only around £5,700, means tested. They were not able to access a loans system.

There were lots of issues with the previous funding reform, which was why we wanted a change in the system. The other issue behind that which is important to understand is that there was a lot of noise about the need to increase the number of the graduate workforce. There is not an endless pot of money to do that. How were we going to do that in a system where you could have very unpredictable numbers?

It was not rocket science. A commissioner could say, "We want you to recruit 228 mental health nurses this year." That is difficult do when you had met your number and were turning people away. Somehow that felt wrong, so we were an advocate of reform and of some challenges within that. Some of the challenges have yet to be listened to or considered in any great depth. We introduced this new system without any national advertising or national campaign from the Government. There was very little information for students around the funding changes in the system. We as a council set up our own website and set up information to try to co-ordinate that gap of understanding.

There are still some issues to think through in relation to mature students and smaller fields of practice that may come under reduced numbers because of this, such as learning disabilities and mental health nursing. It is not a perfect system and there are some issues that are not getting enough airplay in discussion.

Q128 **Diana Johnson:** I want to pick you up on that point. In the last evidence session, we heard that South Bank University stopped running its course on training learning disability nurses. We also heard from the RCN that

the spring intake for nursing courses seems to have been suspended in some universities. The idea that you are going to get more nurses through the system in the very first year seems to be problematic.

Professor Brian Webster-Henderson: I would challenge that slightly. Very few universities have spring intakes. Most universities, not all, run on a one-take-in system per year. I think that is just the fact of the matter. Our deans and departments will tell us that. South Bank may have decided to stop learning disability places because it has not recruited, but it has also jumped into the nursing associate agenda quite heavily as well and is looking at that.

What universities are being asked to do is quite complex because of the plethora of roles and the education needed for them. We do absolutely have to monitor that, because we would not want to see the demise of some of those smaller fields of practice.

Q129 **Diana Johnson:** I am sure you want to say something, Lord Willis.

Lord Willis of Knaresborough: I looked at that as an issue when doing my work. I agree with Brian that I could find no research that was giving us an indication as to whether in fact it would work. I do suspect that this was an attempt to actually move £1 billion from one place to another at the time. Whether it works out in practice, only time will tell.

Is a mum or dad in their mid to late 30s going to come into that system? The answer, I think, is no, but I honestly do not know. Until we actually see two or three years of figures I do not think we will know.

The water has been muddied by the apprentice route becoming available. Here is another route that creates another set of complications. The apprenticeship criteria are significantly different from a three-year graduate course based from a university. There are a lot of complications around this issue. It requires proper data and analysis.

Q130 **Diana Johnson:** Who do you think should bear the cost of educating the workforce that we need?

Professor Brian Webster-Henderson: That is a difficult question to answer from an evidence perspective—a personal perspective would probably be all you would get on that. Nursing is now in the university system like all its other subjects. There have been problems with the commissioned approach to nurse education being very different from the rest of the university sector. We do now have graduate education that is in line with all the graduate subjects within the UK.

Q131 **Diana Johnson:** And that is okay.

Professor Brian Webster-Henderson: I personally do not see a problem with that, no.

Jackie Smith: There is not a bottomless pit of money. That is quite clearly the case. We need to decide what we need in terms of a workforce and be creative and flexible to be able to adapt to that. As you say, it is early days. It is only a year in, but I would hope that whatever system is in place we do not reduce the impact of widening participation. We want to widen participation because that is really important in the nursing workforce. It will be interesting to see what happens as time goes on.

Professor Brian Webster-Henderson: I would much rather be focused on the issues that we know are problematic now. If we know that we think that mature students could be a problem because they might be loan averse, let us think of alternative solutions to try to recruit them into the workforce. It is early to say in smaller fields of nursing, but if it does turn out in a few years' time, when we look at the trend, that there seems to be a rapid decline in some areas, let us put some other incentives in to do that.

Not all the workforce that we are educating is coming in via the same route. We do run post-graduate pre-registration programmes that are outwith this new funding reform. We do not know what the funding reform will have in all of them. Here we are in November 2017 and we still do not know what the mechanism is for them.

Q132 **Diana Johnson:** Is there something specific we could do for mature students?

Professor Brian Webster-Henderson: For example, if they have caring responsibilities or a young family, there could be some kind of financial repayment to help them with looking after children or help them with their caring responsibilities. You could easily put a think-tank together to think through some of the things we might do. Would there be an approach to forgivable loans, in a sense, for some of that? We have laid out some other issues in our evidence that we think would be worth thinking through in a creative way.

Q133 **Diana Johnson:** There is another thing I ought to ask you. We have talked a little about using the knowledge, experience and skills that people have in social care roles or in the unregulated sectors. Could universities get better at recognising that and using it as part of assessments and training nurses for the future?

Professor Brian Webster-Henderson: A lot of that is actually happening at the moment. We have different examples in different parts of the country where we have health and social care integrated problems. There is a lot of social care within nursing programmes. It is different in the four countries because health and education are devolved, and different issues therefore play out to the local market. We have a long history of intra-professional learning and learning with and from other professions. A lot of that is built into some of the assessment criteria and the knowledge and skills that we are giving to that part of the workforce.

Could we do better? I am sure we could, and I am sure that the new standards that Jackie was referring to for pre-registration will make us look at that again.

Lord Willis of Knaresborough: I think we are also getting smarter, with previous learning, at cutting the time that is taken in reaching a graduate qualification. That is a significant move forward. It was very difficult, particularly for a mature student, to have to come in, to do all sorts of things and to get no credit whatsoever.

Q134 **Chair:** One of the points of concern that have been raised with us is that it was the mature students who were more likely to stay as registrants but less likely to take up the degree courses. Does any of the panel feel that we need to act more quickly to put back in bursary routes or other incentives for mature students? Do we need to act now, or can we afford to wait and see how this goes?

Professor Brian Webster-Henderson: When we submitted our views around the funding reforms we always identified that we thought there was a risk with mature students. So why are we not doing something now? My view would be that we need to act now.

Q135 **Chair:** Act now would be your advice.

Professor Brian Webster-Henderson: Yes; absolutely.

Q136 **Chair:** Is that your feeling as well?

Jackie Smith: As the regulator, we are interested in ensuring that we have the right people joining the profession with the right skills. That should come from a diverse range of backgrounds.

Lord Willis of Knaresborough: I would act now. It is not just mature students. You also have to look at parts of the country that are finding it very difficult to recruit and retain staff. We have seen that, for instance, with GPs. There has been a move by the Government to incentivise moving to particular areas. I think that that applies to nurses as well, so that we can get people into some of the remoter rural areas and to stay there.

Q137 **Chair:** Is there anything that you have not been asked that you would like the Committee to know before we finish today?

Professor Brian Webster-Henderson: Yes. One initiative has not had a lot of airplay but is of value in adding graduates to the profession. The CNO in England currently has a project around post-graduate shortened programmes into learning disabilities and mental health, but it is small numbers. If we are thinking about the shape of the workforce, it would be worth keeping an eye on how that initiative plays out. It is definitely a quick way to get people into the workforce and it has not been difficult to recruit.

Q138 **Andrew Selous:** I have two further questions. I want to come back to the issue of placements and the resources that are required. Placements cost money, so I would be interested in all the panel's views on them. Lord Willis made some suggestions about being a bit more creative in the way we imagine placements.

Professor Brian Webster-Henderson: I will take the last question first. I hear what Lord Willis says, but I think the partners of the deans whom I represent and work with certainly are very creative, in that a placement does not have to be just a physical location. We attach many students to practitioners or to teams of practitioners so that they can get a full and varied experience, and still meet the requirements for registration. We have simulation environments where students can practise through simulation. Lots of universities are doing that.

There is already a lot of creativity around placements, but there is always room for improvement.

In relation to placement capacity, it is worth highlighting to the Committee that there is still an issue around the funding of placements. There is a placement tariff, which could be seen as being at odds with an open market for recruitment because only a certain amount of placement tariff is funded. The mechanisms for that funding have yet to be confirmed for this coming year. That seems to be quite an urgent need to address.

Lord Willis of Knaresborough: I totally support that. The issue of placement tariffs is a major one. The one area that does worry me is that the graduate apprentice route has not taken off. We have only seen two providers come forward with proposals for that. That really has surprised me. I thought that would be quite a popular route in. We have to look at these initiatives and ask why they are not pressing the right buttons. We thought that would be an obvious route through for mature students, yet apart from the traditional providers—mainly the Open University—we are not getting them.

Q139 **Andrew Selous:** My final question—and maybe the final one of the session—is on attrition and what we can do to improve the number of students completing their course. The figures I am looking at show a huge amount of variability. We lose an average of 25.1%. Health Education England commissioned 18,000 places between 2013 and 2016. We delivered 11,900 from that 18,000. The variability, as I understand it, is from 9% at the bottom end to 44.5% at the top end, which is massive. What are we doing to bring the worst down, ideally to the level of the best, and spread best practice?

Professor Brian Webster-Henderson: Attrition has always been a major issue, particularly in nursing programmes. The Health Foundation's recent report—"Rising pressure: the NHS workforce challenge"—is a useful document to look at in relation to attrition. It is a complex problem. It has a very different pattern from other subjects you might

see in a university. In most subjects, attrition would be at year one, but in nursing programmes attrition tends to carry on through years two and three. It is difficult to understand that. When you interview students, some of it is around placement pressures and the actual environments they are going into. A lot of it is around the types of students we have recruited in the past and the financial hardships that they have had to bear through the old system. They have had part-time jobs and they have had to then decide, "I need some income, so I am going to do that." It is a multi-complex issue.

Universities do have very different mechanisms. As a council we have had round-table discussions with our deans to look at best practice and to try to improve what universities are doing about it. Most students on these programmes tend to leave through finance or through personal issues rather than—

Q140 **Andrew Selous:** I am sorry, but I am not really satisfied with that answer—a round table to discuss best practice. This is massive variability. It is 9% to 44%. With great respect, you need more than a round table because this is really urgent. If some institutions can deliver 91% and others are delivering only 56% then, with great respect, it needs rather more than a round table. It needs urgent action and a programme to look at what the best are doing to try to deliver that across the board. I am not quite hearing that from your answer.

Lord Willis of Knaresborough: Andrew, can I give you some succour? In 2015, Health Education England introduced the RePAIR—Reducing Pre-registration Attrition and Improving Retention—programme. I have to read it because I cannot remember it.

Q141 **Andrew Selous:** That is a bit of a mouthful. Is it going to help?

Lord Willis of Knaresborough: It certainly is. We have actually seen that the overall reduction between 2009-10 and 2013-14 has started to go down quite significantly, particularly in adult nursing. In other learning disability nursing, it has not. We still have a huge drop-out there. What this programme is doing for the very first time is gathering information as to why students are leaving courses. The information that comes through the student survey does not give you the granular detail to be able to put in place support. Some universities have been able to have very effective buddy schemes. For instance, they have concentrated on year two where there has been a significant loss for them, to do far more intervention with individual students.

One of the real problems is managing student expectations on the course. Quite often, students go with very good ideas as to what nursing is actually going to be, until they go into a placement, which is incredibly challenging and difficult. It is managing them through that period that is very important indeed. I do think this RePAIR programme—which is easier to say than the title—will make some difference. At least we will have some information. At the moment, we do not.

Chair: Thank you all very much for coming this afternoon. We really appreciate it.

Examination of witnesses

Witnesses: Claire Johnston and Avril Devaney.

Q142 **Chair:** Thank you very much. I am sorry that we are a little depleted, but some members are committed to contributing to a debate that has started in the Chamber. Thank you very much for coming. For those following from outside the room, may I start by asking you to introduce yourselves?

Claire Johnston: I am Claire Johnston. I am the project director in North Central London for Capital Nurse, which is a local element of the wider Capital Nurse programme. I am currently on secondment from Camden and Islington NHS Foundation Trust. I am a jobbing director of nursing.

Avril Devaney: I am Avril Devaney and I am a mental health nurse. I am working as the nurse director at Cheshire and Wirral Partnership Trust. I will talk primarily about CWP, but I am also chair of the National Mental Health Nurse Directors group and have contributed to the evidence from that group as well.

Chair: Thank you very much for coming. Rosie is going to start the questioning.

Q143 **Rosie Cooper:** We previously had a fairly long session, and I know you were listening to it. I want to ask how you see the scale of the challenges in your different areas, the nursing workforce in your area and the impact it has on nurses' ability to do their job and care for their patients.

Claire Johnston: The scale of challenges is not inconsiderable, certainly in our STP. We have great ambition in North Central London for care closer to home, for example. I know that the inquiry has been hearing a lot about some of the pressures in social care in particular. From a nursing perspective, because the Capital Nurse project is embedded within the work of the STP, it is tremendously helpful because it means that we are systematically looking at solutions and planning for that nursing workforce in terms of new models, while of course making existing models of care as efficient as they can be.

To give an example of some of those pressures, at the moment it is not always the case that new qualifiers would see general practice nursing as an appropriate first destination post, but we desperately need to have nurses who are graduating moving into primary care. That has been an area of focus for us. In North Central London and east London collectively we have managed to place 160 nurses—many of them new graduates, but not exclusively so—into general practice nursing to alleviate some of the pressures and to make sure that we have that care closer to home working more effectively.

We have perhaps been less successful in social care, but, as we heard from Lord Willis and indeed from Sharon Allen last week, the significance of doing that is not lost on us. Our ambition within Capital Nurse is to make sure that we work comprehensively and in an integrated way with nurses who are working in that care sector. There are too few of them, and it is not yet a specialty within nursing and has perhaps been neglected as a Cinderella.

Capital Nurse is running several programmes that involve those nursing home managers. That can be some quite small-scale schemes—shadowing opportunities and twinning wards. Since presenting our evidence, we have been fortunate in gaining some funding support from HEE to train 25 care assistants to work in nursing home care settings, who have an existing overseas nursing qualification but have not, for whatever reason, registered in the UK and to give them intensive support and development so that I hope we will have very soon an extra 25 nurses working in that sector.

Those nurses are under significant pressure. As you have seen from our evidence, a significant number of them are over 60. There is a turnover rate in our nursing homes of 38% locally, which is just not sustainable. That gives an indication of those pressures, which translate into some of the delayed transfers in social care that then back up into hospital with the lack of the nursing workforce, the loop then on the impact on quality and some of the closures of those nursing homes in the market. That failure of the market then leads to upstream delayed transfers of care. I do not know if that is helpful.

Q144 **Rosie Cooper:** I am sure it is. How would you see joining up that integrated agenda? Most people these days are reacting to delayed transfers by having almost an ad hoc sub-committee that goes through all the cases and tries to get people out of hospital. That does not address the real problem, which is giving community nurses the decision-making power we heard about earlier to get real solutions.

You see the challenges as really high and steep, but you have this bottleneck. You are managing to get nurses into GPs' surgeries, and they are needed, but how will you make a difference in the social care and social health integration agenda? How will you make that attractive?

Claire Johnston: It is a very real challenge to make social care nursing an attractive proposition when the terms and conditions and the pension arrangements are indeed different because it is a very different market, as you of course will understand. However, I think we can begin with some simple elements to which we are committed in Capital Nurse of understanding one another's roles, knowing just how complex and skilled those nurses are who are working in social care, and having that appreciated by our colleagues in cancer care, end-of-life care and emergency care is important.

Last year in our sector there were 3,000 admissions from the care sector to emergency departments or urgent care. Only a proportion of those would have gone on to become admissions to hospital, but a significant number of that condensing could be counted as unwarranted and perhaps not in the best interests of the patient.

If we can make sure, through some of the small-scale schemes that we have successfully introduced, that those nurses feel much more confident and much more skilled, and if we can move to having some shared arrangements with some of that upskilling, which we have begun on a small scale with Capital Nurse, it would begin to make a difference if we can get more students to experience positively what it means to work in our care sector.

I was very proud a couple of months ago to be giving some certificates to our new mentors who will be and have been supporting those students, who had had very positive experiences indeed. I think we need to herald that and show that for a part of your career working in the care sector can be a great option. That is what STPs are about—trying to endeavour together to be creative about the integrated approach. However, I think there are bigger challenges on the horizon, and without some standardisation of terms and conditions the disparity between the two sectors will continue to present a significant challenge.

Q145 **Rosie Cooper:** I will come back to that. I am sure you want to contribute.

Avril Devaney: We provide district nursing services and we have established our first self-managing team. I think that is what the future style needs to be. We train nurses to degree level. We need then to give them the capacity to work to the edge of their practice. You mentioned the STP. I think that gives us a vehicle to look at real transformation because a district nursing team will not be able to do it on their own. It needs to be the whole of the system and the community, looking to what strengths communities already have and building on those so that the nurses are alongside the communities rather than doing to the communities.

Q146 **Rosie Cooper:** Can you draw me a picture of what that really looks like?

Avril Devaney: You might have heard of Buurtzorg, a model developed in the Netherlands. Fundamentally, it is about district nursing. It is about how care is delivered, but as importantly it is about how the team is managed. The team is self-managing, in that it has wider scope for decision making than ordinary teams. They will select colleagues, even if the colleagues are on the same level as them, rather than the hierarchical system that is traditional in the NHS.

We have looked at the best of Buurtzorg, but we have looked at the community that we are working in as well. We have mixed the needs for social care as well as mental health care into the district nursing team. It

can work in a person-centred way rather than in a task-focused way, which has been the traditional way for teams to work. Does that help?

Q147 **Rosie Cooper:** It does. I have been hearing about person-centred care since I got into the health service. We talk a good game but we do not actually deliver an awful lot. I get very bored with it. We can talk a lot about how it should be, but the reality is that people experience how it is. We talk about empowering nurses and making it work until somebody takes a decision, and then things change if it does not fit the pattern you have already.

You have described the best practice idea and the involvement of an STP. How do you think the STP will be able, without legislation, to get people on board and deliver different results—not just in the speaking classes, as I call them, but actually at the frontline?

Avril Devaney: It has to be through the transformation element. We have used a description that we have a production line that produces diesel engines and what we want is an electric engine. At the moment the system is still geared up in a way that is siloed. The transformation has got to happen for us to be able to move into that. Individual organisations cannot do that alone. It needs to be the whole system and community transformation.

Q148 **Rosie Cooper:** How do you get the community to buy into that?

Avril Devaney: It is really difficult. For many years we have trained communities to expect that services will go in and fix things, when actually what we need to be doing is getting alongside communities much more and helping them to help themselves and to stay well for as long as they can.

It has been a long time since I have heard the level of commitment that there is to actually making it happen now. I know that each area is in different places. Of course, I am very concerned about mental health—one of the things that we deliver. As a nurse director I have to give my full commitment to that transformation because unless we are all in it together it is not going to happen as a transformation.

Q149 **Rosie Cooper:** How are you doing your workforce planning? We talked about engineers, electricians and all the rest of it. Now we are actually talking about system change, but we do not know what we are going to need because we do not know the end result.

Avril Devaney: The other challenge we have is that we struggle to really understand the individual population needs. That adds to the challenge. The ideal would be that you start with the population and understand what pathways you want from there. Then you would know what skill mix you need to be able to deliver that. But we do not have that. We are doing shedloads, and I think there are some really exciting things going on in mental health that I hope to get a chance to tell you a little bit

about, as well as the very real challenges we are facing. There are things that we are able to do now. The nursing associate pilots is one of them. We are also part of the RePAIR pilot that Lord Willis mentioned. We are part of the accelerated masters pilot that Brian mentioned earlier.

There are things that we can do now to shape our skill mix. We are thinking about population needs in five to 10 years when most of the care will be delivered at home or close to home. It is making that leap into thinking about what care will look like in the future. In mental health, of course, we have a track record already of moving in that direction. For many years we have been providing most of our care in the community.

Q150 **Rosie Cooper:** My length of experience in the health service has been that with workforce planning we have either got too many or not enough, and on we go. It is incredible. Are we talking more about skills now?

Avril Devaney: It is skill mix.

Q151 **Rosie Cooper:** That should be better. I can only hope that those areas that you are describing will repair the problem as you see it. It is very difficult. So many STPs come up with so many different solutions for so many different populations.

Avril Devaney: Yes. There were days when we used to get the blueprint and then every locality had to apply the blueprint. There were some benefits with that because there was some standardisation, but there were losses as well because it did not take account of community needs. It is almost like we are in the transition. We are going from quite a centrally controlled standard setting to being much more locally accountable for what we do.

Q152 **Dr Williams:** General practice nurses often work in very small organisations. Nurses working in nursing homes and social care are often again working in quite small organisations and are sometimes professionally isolated. They are sometimes without strong leadership. There are community nurses and district nurses. Is there a case for an integrated, single, out-of-hospital nursing workforce on a locality basis?

Avril Devaney: Traditionally, nurses have been very well networked. Commissioning structures in recent years have meant that we have worked more in isolation, but that is opening up again now. At the moment we provide to GP practices in our area, so those practice nurses are well linked. We also support care homes. When revalidation came in, we were involved in supporting care homes in getting ready.

I think there is a real appetite for it. I do not know that it needs to be one organisation. If the doors are open, it does not really matter which organisation you work for, as long as the outcomes are right for the patients.

Q153 **Dr Williams:** It strikes me that when you are isolated it makes it difficult. There are often fewer incentives to invest in continuing

professional development if you work for a small organisation. It also strikes me that there is not necessarily a career path that is as obvious in out-of-hospital nursing as there is within hospital nursing. I understand that it does not necessarily need a single organisation, but it needs people to feel that they are part of the same team perhaps.

Claire Johnston: Yes. You are right that it needs a better level of attention, but I do not think the solution would be, as you have perhaps acknowledged, the single organisation or management of primary care and community care. Mental health is largely community care, and 97% of it will be in that community. Encouraging nurses to work in those environments and making sure that they have decent careers is something that we have to have more ambition about. It is fantastic that we now have the 10-point plan for general practice nurses. That is something we can all get behind to make it happen at local level. I have already talked about how we need to bring more new graduates and younger nurses into general practice nursing. We have an older nursing workforce in community mental health as well. We have to think about how we can revitalise those professional routes for nurses and make sure that they see them as attractive.

Again, it is back to ensuring that there are opportunities right from the get-go to break the mould, certainly for social care, practice nursing and community nursing, and see that you do not always have to do a year in a ward before you come out into the community. That has perhaps been the traditional thought. The NMC changed the rules about that ages ago. We want to promote that as an opportunity for people to be working in those community settings. I think our evidence demonstrates that we can begin to do that at small scale and that, indeed, it could be replicated.

We could offer at postgraduate level beyond the preceptorship year, which we heard about from our colleagues, the opportunity for rotations—a scheme whereby you have maybe 18 months, which is your postgraduate years two and coming up to four. By choice, you might do a period of time in practice nursing and you might then do work in social care and in an acute linked specialty, which will be attractive for some people, but it is giving those nurses options so that they will see community careers, which Avril and I have both worked in and are hugely committed to, as being compelling, attractive and wonderful places to work.

The isolation for some of those smaller elements means that they cannot always commit financially to the same things as larger trusts. We need to think and work with our GP federations to make sure that those practice nurses are not losing out. Again, there are issues around terms and conditions and whether there are different hosted employment models or other opportunities. We have been helped very greatly in London by the HEE funding of CEPNs—the community education provider network—as a way of bringing communities and learning and skills together, both in

health and care, for the future. I think that has helped some of the smaller professions.

Q154 **Dr Williams:** It has allowed an investment in ongoing education that is not coming from a small organisation; it is coming from a larger fund, is it not?

Claire Johnston: Yes, and we are sharing that together.

Chair: We are coming on to develop the theme around retention, and Johnny is going to lead on that.

Q155 **Johnny Mercer:** Looking at nursing at the moment, in other organisations when there are particular challenges, there are often pinch-point trades into which people struggle to recruit. Where are they at the moment, and what are people doing locally to improve the situation, particularly with recruiting into those trades?

Claire Johnston: Retention is an issue across the board. You will have seen in our evidence that we focus particularly on the benefits that can be gained from focusing on the retention of our new graduates and then offering them the right sorts of packages and programmes so that they can progress in their careers.

Q156 **Johnny Mercer:** So, a specific drop-off point is new graduates coming in and then they get cold feet and leave.

Claire Johnston: Yes; it is a drop-off point. Our figures demonstrate that we are losing 19.6% of those new graduates within a year. That is an unacceptably high level. I do not know whether those figures would be typical across the UK. There may be some variation, but we must provide the right elements of support and development for them. Capital Nurse developed a London-wide approach to preceptorship, which is about transitioning into nursing. We must not infantilise the profession. I felt there was a slight indication of that from one of our earlier speakers.

New graduates in nursing are probably the best trained they have ever been and our universities are doing a fabulous job, but, for any profession, that transitional phase to build up your confidence and to make sure that you are feeling supported is crucially important. Having a London-wide standard that means that we can address that and take into account the research, where we know there is that drop-off point, as you put it, is significant. So, we put some of our focus and energy there.

Another area would be with older nurses who are 50-plus. In North Central London, in our STP, that amounts to some 20% of our nursing workforce. We do not want to lose all those wonderfully experienced nurses, so again we need to think, as we have been endeavouring to do by listening to them, what will help them to stay working for us for longer. They are looking for different things from our younger workforce. We have to think about what works at an early career, mid-career and for a face-off career.

Q157 **Johnny Mercer:** Avril, did you have anything to add on that?

Avril Devaney: In terms of where the pinch points are, the feedback from the forum would be that CAMHS is a real challenge. That is obviously somewhere where we need to grow the workforce to be able to respond to demand.

Claire Johnston: Also, learning disability funding. We heard from Brian earlier about learning disabilities nursing. The number of applicants to BSc programmes this autumn was 68% down. That means that in three years' time we are going to have very few nurses.

Q158 **Johnny Mercer:** Do you know why that might be?

Claire Johnston: I do not know for certain. I do not think it is linked to the bursary issue. However, I guess there is the post-Winterbourne effect and there is not really a strong career progression in learning disabilities nursing. Many of our learning disability nurses work in industry, in a social care setting. Again, it is back to this issue of how we can create those imaginative care pathways.

However, it is a very different kind of nursing. You are developing those longer-term relationships. It is at a different pace. You are almost seeing through a lens many aspects of a person's life with LD and the impacts of perhaps a psychosis if they have dual diagnosis, or their diabetes through that nursing lens. They are highly skilled nurses and we need more of them in general services, not just LD. This is an area where we really need to focus. Some of them have come through the postgraduate diploma routes in the past.

I think we heard Brian say here that for that minority specialism the Nurse First programme—a programme of investment that just started this autumn and has taken learning disabilities and mental health nurses at postgraduate level—has been a great success. I think that there needs to be a greater investment in postgraduate programmes for LD, perhaps partnering up with something like Think Ahead, the social workers' programme.

Q159 **Johnny Mercer:** That is interesting because that was going to be the next part of the question. What can we do nationally? What can we chivvy along the Government to do to fill some of these particular pinch-point trades?

Claire Johnston: If there were the postgraduate option, if we were to make a special case—given that the decision has not finally been made, as I understand it, on funding for postgraduate entry—then I think that would be something attractive for learning disability.

Avril Devaney: I think we need a concerted campaign on what nursing is about in 2017. We have not had a joined-up campaign in the same way that we have for other sectors. It is long overdue. I do not know, unless people have a connection with nursing, that they really understand what

it is like, or they think it is like "Holby City." It is very different, certainly in mental health and learning disabilities. The things that we can do in 2017 are very different from what we could do 10 or 20 years ago.

Q160 **Johnny Mercer:** Do you think there is an element of the perception of challenge around health at the moment? I know, for example, at my local hospital, generally we never hear about it until something has gone catastrophically wrong, but if you look at their markers and how they are doing it, it is a world-class hospital providing a world-class health service. Unless we control that now, we are not going to get people into the profession. Is that fair?

Avril Devaney: I think that is a big challenge. We are also looking at the moment at the impact that the added public accountability is having. Claire has already mentioned Winterbourne View, but there have been changes in the way that coroners' courts handle homicide investigations, safeguarding investigations and domestic violence. Unlike doctors who are supported in their core training to expect and withstand that kind of scrutiny, nurses do not have that. Very often, it is a shock. It might happen only once in their career, hopefully, but it can be a tremendous shock to them. Of course, the local press pick up on that. Again, it adds to that image that it is always going wrong in mental health, when, actually, we are saving lives every day.

Q161 **Johnny Mercer:** In other professions, certainly, there is an element of continuous professional development to increase the retention rate of people who work for us and increase their skills so that they want to be part of the organisation and continue to build their career. Do you think there is enough of that in nursing?

Avril Devaney: We can do a lot more.

Q162 **Johnny Mercer:** There has been quite a significant budget cut.

Avril Devaney: Yes. Some of it is about core training. That professional accountability needs to be understood right from the start. In terms of resilience and professional development, that is a career-long building. You need resources to be able to do that to support the staff. It is the attachment to a profession that you get, and the revalidation. I totally agree with what Jackie said. It has been very affirming for nurses to go through that process, but we need more of it to keep building that attachment. As Claire has also alluded to, different generations need different approaches. It is not a one size fits all.

Claire Johnston: Nurses expect a level playing field with other professions when it comes to continuing professional development. Our medical colleagues are trained for the roles that they fulfil. Our psychologists are paid as they go along in their training as well. I think the level playing field matters. Jackie talked about revalidation, and we have been endeavouring to do some work in London through Capital Nurse.

Take our chemotherapy passport. We found that cancer nurses were frustrated because there was not a standardised approach to the important work of administration of chemotherapy. Furthermore, if you moved from Bexley to Bromley, you would be expected to undergo that training again, which is wasteful and of course means that there is a time lag there. You have moved jobs but you are not able to exercise those skills.

Cancer nurses across London, through our cancer network in Capital Nurse, were brought together. They had been struggling to do this for a while, but, with a bit of support and a standardised approach, we have now produced a passport that was launched with the United Kingdom Oncology Nursing Society in September. UKONS have just had that launch for their own organisation this month. Now, provided you follow that assessment and you are supported to do that assessment, that is transportable. We are piggybacking on working with our HR colleagues so that there is hope in the future for much more of an employment portability, which means that we will not have to replicate that CPD element.

There are some efficiencies that we can make. That is not saying that we do not need continuing professional development, but we are trying to think as imaginatively as we can about how efficient we can be in the delivery of those kinds of programmes.

Q163 **Diana Johnson:** Claire, you mentioned in passing the removal of the bursary when training to be a nurse, and about its effect. Could you say a little more about what your experience is generally on the changes to funding of undergraduate nurses?

Claire Johnston: I have mentioned one of the only negative impacts I have been aware of, which is the learning disability programme. Perhaps there are particular reasons for that. What we do know is that the universities have in the main successfully filled those places this autumn. Perhaps it is too early to tell, as we were learning from our colleagues earlier, what the longer-term impact of those bursary changes is going to mean.

We will of course endeavour to make sure that, from the trust's perspective, we are working fully in partnership with our partner universities so that we can keep our part of the deal, which is to make sure that in practice there are those high-quality clinical placements of the most imaginative and fulfilling nature that we can make that are appropriate for the new graduate programmes. We really do not know what the longer-term impact is going to mean. It certainly is the case that we appear to have had a younger cohort this autumn. I guess that was predicted. Perhaps it is back to the kind of era that I remember of nurses coming in at a younger stage.

What that will mean is that it is possible—we do not know—that the attrition difficulties that we were talking about earlier may change due to

younger students moving from home, especially if they are coming to the capital from somewhere else. Life happens, so it is more than possible that we may need to think about additional support for those younger students. That brings us back perhaps to what seems to have been a theme since Robert Francis was at the Committee last week, in thinking about supporting those students emotionally and pastorally, and ensuring that those aspects of reflective practice are truly considered. That may mean some further investment of time and support. Beyond that, I do not think we can say.

Q164 **Diana Johnson:** Avril, what are your views about the changes to the funding?

Avril Devaney: I am worried about mental health and learning disability, because we have traditionally relied on more mature people coming in for training. I worry about people who already have a degree and who sometimes make a switch later in life. If we have a range of routes in, then we will not rely on only one route. Going forward, as new opportunities arise, time will tell us whether the reliance that we used to have on the bursary kept that flow coming through, or whether there are other innovative things that we can do as well.

The other thing I would add is that there might be particular groups—I am thinking of BME groups—where we might need to think about doing additional things in terms of a bursary. That would need a lot of thinking through.

Q165 **Diana Johnson:** I just wondered in terms of your particular area. Do you border with Wales?

Avril Delaney: Yes.

Q166 **Diana Johnson:** In Wales, they have the abatement programme. If you commit to a certain number of years' service in the NHS, then your loan is wiped out. Is anyone talking to you about that and saying that a young person in Cheshire might go off to north Wales rather than train in England because of that? Are you hearing that?

Avril Devaney: No. I am not sure it is very widely known. As it does become known, maybe that will be an issue. There will be all kinds of dynamics that develop because of that. We have the same challenges with nursing associate roles being developed in England but not being developed in Wales. There are challenges along the way, but there always have been. There are differences in the Mental Health Act as well in the four nations.

Q167 **Diana Johnson:** In terms of mature students, do either of you think there are things that could be done now to ensure that they come forward to train to be nurses?

Avril Devaney: We are part of the Nurse First pilot. All four of our trainees are people who were already working as support workers on our

wards, carrying 2.1 degrees. If we can build opportunities like that, then we will keep things open because they do not have to go and do a first level degree of nursing; they will go straight to masters level. They were all psychology graduates.

Claire Johnston: We talked about the support at postgraduate level and the maturity that those entrants can bring. That is fine if you have a degree and therefore are eligible for those programmes. We have to be careful if we are talking about special dispensation. I am thinking about "mature," whatever we define that to mean. You could be 20 and on a programme while having two children or be caring for an elderly mother. The system is building in the support right the way through that bursary programme and we need to consider it for all citizens. I wonder if it might be more difficult to positively discriminate for maturity.

Q168 **Chair:** It is a very good point about where you would draw the line. I want to develop the theme around the new routes into nursing and be clear about your own experience of these routes and what the benefits and some of the problems might be to look out for—for example, around apprenticeships and nursing associates. Starting with apprenticeships and speaking for your own organisations, what have been your experiences with that?

Avril Devaney: Our local university has just gained validation, so we are clearly looking at it. The difficulty will be the cost because, currently, there is no backfill. That will limit it from the start because provider organisations just do not have the resources. The brilliant thing about it is that it is an opportunity to grow our own, which is exactly what we want to do. We want to be growing our own from the communities that we serve. It gives us a real opportunity to do that, and it builds that umbilical cord as well.

We welcome that opportunity, but we have concerns about what will happen at the end of it when they are newly qualified. Over a longer period and then working alongside graduates who are in debt, those kinds of challenges will emerge with those kinds of differences in the workforce.

Q169 **Chair:** A point that has been made to us is that it is not a cheaper route into nursing overall and it is not a quicker route into nursing.

Avril Devaney: No, it is not. It will work for some people.

Q170 **Chair:** It will work for some people. Claire, was there anything you wanted to add to that?

Claire Johnston: I am only echoing what you have heard from other panellists. We must not throw the baby out with the bathwater. The baby is our registered nurse, who is not a baby. It is that registered nurse who has to be the fulcrum of how we manage and organise care alongside our medical and other colleagues. Certainly, in mental health and acute care, we are well used to working with a rich mix of colleagues in

multidisciplinary teams because that is the way we deliver the best care for patients. We have peer support workers, who are service users providing very valuable roles. We have dementia navigators. We have nursing associates at the moment and apprentices of other hues. There is a multitude of people who are all very clear about the contribution they can make. Let us welcome in the nursing associate and the nursing apprentice, but, as we were hearing earlier, we need to be very clear about the boundaries and scope of that practice. We must make sure that our registered nurses feel absolutely prepared and able, as I know they will be, to ensure that the limits are managed so that there is appropriately delegated care. Then we get the very best things that we need.

For example, in crisis care in mental health, it might be that, once our registered nurse has done that assessment and prescription of what care is needed, then the very next best person might be that nursing associate as they come on line. They might visit that person in crisis at home six times a day or for a short period of time, report back on their mental state and make sure that the registered nurse is absolutely clear about the position. That is still a whole lot better for that patient, if we are managing care in that way, who has not been admitted and who has been able to be taken through that crisis with the help of that team. Both Avril and I are working with nursing associate pilots in our patches, which are imaginatively scoped with the involvement of social care, hospices and—in our case—a social housing provider.

Those nursing associates are going to be building up very flexible skills that will be perfect for our new future. We must not go overboard and think that that is the panacea for the future. We have heard an awful lot about new routes and new roles. Let us focus on what we really need to think about, which is our existing nursing workforce and our workforce for the future.

Avril Devaney: It is that whole skill mix. In the same way that we do not want to see any erosion of the degree, we also want to see more advanced practice and nurse consultants. It is getting the whole skill mix right. In our workforce modelling, we are thinking about the whole nursing family—not just nursing associates and degree nurses.

Q171 **Chair:** You do not finish at one point in time; it is a continuous spectrum of development.

Avril Devaney: In our pilot we have 44 trainee nursing associates. Part of the interview process was that we asked them—I know we can't hold them to it—if they would be willing to work as nursing associates, at least for a couple of years before they went on to do a degree, if that is what they chose to do. We have had a very interesting response from our nursing associates.

The other difference that Jackie did not mention is that it is unlikely that the nursing associates will be branched; they will be a person-centred part of the nursing family.

Q172 **Chair:** So, generalists.

Avril Devaney: Yes, except that they wouldn't just be able to work anywhere because in two years you cannot train somebody to work anywhere. They will have essential nursing skills that will be portable. Then they will get trained on the job in the setting.

Q173 **Chair:** I will come back to that point. You mentioned earlier the issue around passporting of skills, such as having chemotherapy administration skills that work wherever. Do you feel that there is an issue, as others have raised with us, about nursing associates and there not being a standardisation of what their role would be? You could be a nursing associate in one part of the country and take those skills anywhere else in the country for them to be recognised.

Avril Devaney: There is a standardisation. When we bid, HEE was very clear at the outset about what had to be in the programme, but there was also scope for variation because it is a pilot. Our pilot has been very clear that our trainees spend half their time in learning disability and mental health traditional settings, and half their time in physical healthcare settings. We have gone beyond organisation. In our pilot we have three acute trusts: two for mental health—community and physical healthcare trusts—and a community trust. The nursing associates are moving between those trusts.

It comes back to the point I was making earlier. It does not really matter what organisation you work for as long as there is an understanding and a connection. We have been very clear from the outset that we are looking for a person-centred nurse. We are not looking to grow mental health nursing associates. We are looking to grow person-centred nursing associates, who will bring something to the skill mix that is not currently there.

Q174 **Chair:** Thank you for clarifying that. Avril, do you want to make any more comments about the Nurse First programme that you are developing?

Avril Devaney: Again, it is not a panacea. It will work for the people who already have a degree and the millenniums, who are going to be looking for three or four different pathways in their career. It is a fantastic opportunity for people like that, but it is not instead of the traditional ways through a degree, gaining experience and then moving on to your masters.

Q175 **Chair:** Let me check that I have heard both your views correctly. The message I am getting is not to forget the core routes into nursing; these add value but they must not distract from the core.

Claire Johnston: Part of that core has to be exactly as you are saying—that graduate entry route. I think we need a decision on what is going to happen about those postgraduate programmes. I am sure that will be forthcoming.

The Nurse First programme, although relatively modest, appears to have been a runaway success in terms of how rapidly those places were filled. I think the coalition Government's creation of Think Ahead and Frontline for mental health and children's social work is now the 63rd most popular graduate profession. It does not sound too high, but it has come from nowhere in the last three years. Looking at their business model and thinking for some of the specialty areas would be a good way to grow Nurse First.

Q176 **Chair:** So you would like us to focus on that.

Claire Johnston: I certainly would for London, yes.

Q177 **Dr Williams:** My question is about recruitment. We have asked this of most of the people who have come before this inquiry. How important will it be in the future for the NHS and social care services to be able to recruit people from EU countries and from non-EU overseas countries?

Claire Johnston: In North Central London, you have seen from our evidence that we have a significant component of nurses from the EEA. It is some 17% across the board. It will be different in different parts of the country. As Lord Willis said, it is highly likely that we will be reliant, certainly in London, on international recruitment for some foreseeable time to come. Despite the great efforts that are being made—and we heard the Secretary of State just this morning or yesterday talking about yet further increases in nursing, all of which are welcome, as are the new routes—I think we need a single, centralised approach to that international recruitment that is really beyond any individual trust.

This is certainly something within Capital Nurse with our HRDs that we are beginning to think about with Oliver Shanley, chief nurse for London. It probably goes beyond nursing. I am conscious that we also need to make that non-EU recruitment easy. It was very interesting listening to Jackie Smith as chief executive of the NMC on the efforts there.

I am also mindful that if we are thinking about that longer-term approach—although I do not know very much about it, other than it sounds like the kind of strategic plan that will perhaps be helpful for us if we are looking at that 10 years—the German Government have the equivalent of a bilateral agreement with the Philippines. That means that, because Germany has said it needs 200,000 additional nurses over the next decade, particularly in areas such as elderly care, which despite its best home-grown efforts it cannot manage, it has established an arrangement whereby nurses who are training in the Philippines know that they are going to go to Germany. They spend a year learning fluent

German and clinical German so that they can then go and operate in Germany.

If we are genuinely going to be looking at international recruitment for some time to come, then we have to look at what other countries are thinking about and doing to see how we can manage that. As you have seen from our evidence, if 20% of our nurses are over 50 and a significant number are from the EEA, we have to think of every possibility that we can to retain a suitable nursing workforce for the needs that we face moving forward.

Avril Devaney: I think that we need to have a strategic approach, as Claire says, because different organisations do different things. If we are going to be the best that we can be, then we need that diversity. The question is how best to bring in that diversity and retain it safely. For me, that needs to be done strategically. I know that different organisations are thinking differently now. It is not all about going out and bringing in nurses especially from developing countries. It is more about bringing in undergraduates and thinking about training them, which is a completely different way of looking at it. It helps out the home country as well as helping us out, and it shares the skills.

We have a link with a hospital in Uganda and I have learned a lot about community resilience from seeing how they operate without the same statutory organisations that we have.

Dr Williams: I have just seen that for myself.

Avril Devaney: Then you will know what I am talking about and the way that they involve families and build community resilience. Everybody who comes into the ward is expected to bring a family member with them, who stays with them for the whole time they are on the mental health ward. There is not the disconnect that we get in this country and the family are fully involved in the care. When they transition out, they go with the care that the family is providing, and they have been shown how to do it. It builds on the public health aspects of everything we are trying to do.

Chair: Thank you very much for coming this afternoon. It has been really interesting to hear your expertise, and thank you for what you are doing.