HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: NHS nursing workforce, HC 408

Monday 20 July 2020

Ordered by the House of Commons to be published on 20 July 2020.

Watch the meeting

Members present: Meg Hillier (Chair); Olivia Blake; Sir Geoffrey Clifton-Brown; Dame Cheryl Gillan; Sir Bernard Jenkin; Mr Gagan Mohindra; James Wild.

Gareth Davies, Comptroller and Auditor General, Ashley McDougall, Director, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-102

Witnesses

I: Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; Ruth May, Chief Nursing Officer for England, NHS England and NHS Improvement; Professor Mark Radford, Chief Nurse, Health Education England; Lee McDonough, Director General, NHS and Workforce, DHSC; and Prerana Issar, Chief People Officer, NHSE&I.

HOUSE OF COMMONS

Reports by the Comptroller and Auditor General

The NHS nursing workforce (HC 109)

Managing the supply of NHS clinical staff in England (HC 736)

NHS financial management and sustainability (HC 44)

Overview of the UK government's response to the COVID-19 pandemic (HC 366)

Readying the NHS and adult social care in England for COVID-19 (HC 367)

Examination of witnesses

Witnesses: Sir Chris Wormald, Ruth May, Professor Mark Radford, Lee McDonough and Prerana Issar.

Q1 **Chair:** Welcome to the Public Accounts Committee on Monday 20 July 2020. We are here today to look at the nursing workforce in England. This is on the back of a National Audit Office Report on the nursing workforce, something we have been interested in for some time as part of our work on the NHS. It is great to have this detailed Report.

Nurses make up around a quarter of all NHS staff, yet there are an estimated 40,000 vacancies in nursing posts—although figures around covid may have altered that broad figure. We will ask about covid a little bit, but we are really interested in the systemic issue of whether we have enough nurses, whether they are deployed properly, and how we are going to fill the gaps and make sure that we have the training flow-through necessary to ensure that we have a long-term, consistently well-staffed workforce in nursing—mainly in hospitals, but not just in hospitals.

I want to turn to the Chief Nursing Officer, but let me introduce our witnesses first. We have Sir Chris Wormald, who is the permanent secretary at the Department for Health and Social Care and a regular visitor to this Committee. Welcome to you. We have Ruth May, the Chief Nursing Officer for England, who is based at NHSE&I; Dr Mark Radford, who is the chief nurse at Health Education England; Ms Lee McDonough, who is the director general for NHS and workforce at the Department for Health and Social Care; and Prerana Issar, who is the chief people officer at NHSE&I—that is NHS Education and Improvement, which is a relatively new amalgamated body.

Before we go into the main questions, I have a question for Ruth May. You were one of the people who attended the five o'clock press conferences that we were all gripped by and glued to, especially in the early days of

covid-19. There were reports that you were dropped from a briefing on 1 June. Are those reports correct?

Ruth May: Thank you very much, Chair, and thank you for holding this hearing today. It is indeed true that I was dropped from the briefing, but that happens to many of my colleagues as well. That is a regular occurrence. What I have to say is that I was also asked to attend another briefing later in June, but I got stuck in traffic for that one.

Q2 **Chair:** You were dropped. You say that is not unusual for your colleagues. Was there any particular reason that you were dropped? Were you preparing for that briefing before you were dropped?

Ruth May: Yes, I prepared for all the briefings, like I prepared for this briefing. Absolutely—it is important to prepare for briefings.

Q3 **Chair:** So you were ready for it, yet you were dropped. Why was that?

Ruth May: I don't know why I was dropped, Chair. I do know, though, that I was prepared to go to No. 10 at a later date.

Q4 **Chair:** Were you, at any point in the preparation for that press briefing, being asked to defend the actions of one of the Prime Minister's senior advisers?

Ruth May: As in all press briefings, we talked about lots of these preparation questions. Yes, of course, I was asked about lockdown and rules to lockdown.

Q5 **Chair:** What are your views about lockdown and the actions of Dominic Cummings at that time?

Ruth May: I believe—in my opinion—the rules were clear. They were there for everyone's safety, and they applied to us all.

Q6 **Chair:** So to him as well as to me and you.

Ruth May: They certainly applied to all of us, including me.

Q7 **Chair:** Thank you very much. So it seems that, just to be clear, you were saying that, and after you said that—do you think that is the reason you were dropped from that briefing?

Ruth May: I don't know why I was dropped from the briefing. I'm afraid you would have to ask other people for that.

Q8 **Chair:** So they didn't even give you the courtesy of an explanation after you had done the preparation for what can be quite a gruelling session, especially if you do not do it every day.

Ruth May: I don't have a reason as to why I was stepped down. As I have said before, people are stepped up and stepped down at short notice. I know my colleagues have been stepped down, too. It isn't unusual to be stepped down.

Chair: Thank you very much, and thank you for what you have done.

There were very few women at those briefings, so it was a great shame that you were not there on that occasion. Dame Cheryl Gillan is going to ask you a couple of questions.

Q9 **Dame Cheryl Gillan:** Thank you, Chair. You took the thought out of my mind. I was going to say how refreshing it was to hear some female voices at those briefings. Congratulations, Ms May, on your appearances when you made them.

I want to know about the numbers of nurses, particularly retired nurses, or maybe nurses who were not working in the NHS, who volunteered and came back to help out in the crisis. Do you have the numbers of those nurses that returned to the NHS, and perhaps are still working there now?

Ruth May: Yes, it was a great privilege to be able to stand at No. 10 and represent my profession, so thank you for your words on that, Dame Cheryl. Nurses across England and across the globe have really stepped up during this global health emergency. It has been a privilege to lead the profession during these times. We invited a whole range of people to support us on the frontline, including those people who were returners to the NHS. More than 10,000 nurses stepped forward to support us, as well as over 20,000 student nurses who stepped forward, and over 2,000 overseas nurses also came and supported our colleagues and patients. I am very proud and want to put on record my thanks to everyone that stepped forward.

Q10 **Dame Cheryl Gillan:** I think, Ms May, we would all say that. We are very grateful to each and every one of them. Those are particularly large numbers of nursing personnel. Have any indicated that they would like to stay permanently within the NHS? If so, what are those numbers?

Ruth May: I don't have those numbers at the moment, but each provider and director of nursing and each chief nurse of a hospital or a local community organisation is having direct conversations with those people as to whether they want to stay permanently, whether they want to be the bank so that we are able to call on them again, or whether they are able to do other areas of work for us: for example, work at home and online as part of online consultations or digital support for NHS 111. We would welcome all of the people back. Between now and the winter, it is going to be a really important theme in our work area so that we can keep as many of those people to support us.

Q11 **Dame Cheryl Gillan:** Bringing extra nursing staff into the NHS in such a short period of time must be very valuable for all of us in the staffing of the NHS, because we have got nurse shortages. Are you taking any other actions to retain their services, apart from those one-to-one conversations within the individual trusts?

Ruth May: Retention has been a big piece of work that we have been doing since 2017, and we have seen fantastic improvement in our leaver age. I know other colleagues will want to come in on retention, but, with regard to the returners themselves, we have got to have a better system

locally for keeping those returners. We also want to make sure that we find out in more detail what their level of skill is. We have learnt through covid about the need for skilled practitioners and skilled nurses in rehabilitation, and want them to do that. We also learnt that we needed high levels of critical care nursing and respiratory expertise. Between now and the next couple of months we are going to work to make sure that we understand what each and every one of them wants to do, how we can support them into local practice and how we can keep them.

Dame Cheryl Gillan: Thank you very much. My colleague Olivia Blake will return to the retention question later in the session, but thank you once again for those answers and thank you to all those nurses that stepped up to the plate.

Q12 **Chair:** I am going to ask Sir Bernard Jenkin to come in in a moment, but I just want to ask Ruth May about the 2,000 overseas nurses coming to our aid. Given the global nature of the pandemic, can you unpack that figure a bit more? Where did they come from? Had they previously worked in the NHS—is that why they came back to us? Or were they overseas nurses living in the UK?

Ruth May: It was the latter. It was 2,250 overseas nurses who were working in the NHS here in England as band 3s or band 4s waiting to get on to our register. So with the support of DHSC colleagues, the Nursing & Midwifery Council and, of course, the Royal College of Nursing and other unions, we had an agreement to invite overseas nurses to join the emergency register. I am grateful to every one of those who did. What we need to do in the next few weeks and months is support them to do whatever they need to get on to the permanent register so they can be a long-standing part of our workforce.

Chair: Thank you very much indeed.

Q13 **Sir Bernard Jenkin:** I do not want to gloss over the question of the women's voice in decision making in health policy and the covid crisis. Most politicians are men, most of the people who run the health service are men and most of the senior leaders of the other medical professions are men. What proportion of the nursing workforce identify themselves as women?

Ruth May: I am going to have to come back to you on that one, unless my colleague—

Chair: I can perhaps help a bit. Figure 6 of the National Audit Office Report has 88% of all nurses in the NHS as female. Of course, there are nurses outside the NHS. Is there anything you want to add to that?

Ruth May: I apologise. It is going to be above 80%. About 80% are female, and that has been a fact of life in nursing for many, many years. One of the things we need to do is continue to encourage men into nursing. We have been doing that this last couple of years, supporting schools regarding stereotypes and supporting young boys and teenage boys to consider nursing as a career.

Q14 **Sir Bernard Jenkin:** We might come on to the question of retention and recruitment, because we are depending on retaining and recruiting a very large number of women. What are the things that affect women but perhaps not men, or that men possibly do not instinctively understand?

Chair: That is a big question.

Ruth May: I am afraid I am not able to comment on what men do not understand, not being one.

Sir Bernard Jenkin: I am often told by my wife what I do not understand.

Chair: Have a go, Ruth May, and then we will be moving on.

Ruth May: I do not want to comment on that.

Mark Radford: May I answer the question, as a man in nursing? Ruth is absolutely correct, of course, that around 10% to 12% of the nursing workforce are male, and what is critical is that that has been the case in England for a number of years. As Ruth rightly pointed out, our strategy is absolutely about raising the professional status of nursing for all genders. That is critical. Experiences internationally show that where there is equality and a high degree of respect and understanding for the graduate nursing role, we see increases in both men and women joining the profession.

One has to respect, of course, that with a more female-dominated profession, there has to be flexibility—for all genders within nursing. I am sure that when we come on to areas such as retention, there are important aspects such as professional development, flexibility of careers and support, but they apply equally to men and women in nursing, and I think our strategies are aligned around that.

Sir Bernard Jenkin: I will leave it at that but let's keep it in mind as we go through the session.

Chair: Thank you. We will move on to the main session. We all have the National Audit Office Report "The NHS nursing workforce", which I recommend to anyone watching. Gagan Mohindra will kick off for us.

Q15 **Mr Mohindra:** Thank you, Chair. Can I first declare for the record that I am a councillor? I will be referring to social care.

Prerana Issar, I understand that you were the lead on the NHS People Plan. Can you explain why social care was not included as part of that plan? As a layman, it seems the workforce for social care is in the same pool and same system as the NHS.

Prerana Issar: Good afternoon, and thank you for the question. The NHS People Plan was committed to in the NHS Long Term Plan, which was released and published in January 2019. The commitment was that we would bring NHS service planning, financial planning and workforce

planning together in one strategy. The interim People Plan was published in June 2019 and, since then, we have been refining the overall strategy.

The focus has been on the NHS Long Term Plan. Therefore, it covers healthcare and the NHS. For overall strategy for social care, I would refer to my colleague, Sir Chris, from the HSC.

Mr Mohindra: Sir Chris, do you want to give it a go?

Sir Chris Wormald: Prerana has already answered the question. The People Plan was focused on the NHS—that was its objective. We seek to look at the health and care workforce in an integrated way. Indeed, Health Education England looks at both—Mark might want to comment—but, as you and others on the Committee will know, it is a very different type of service, with a very different employment structure. Therefore, different approaches are needed in the NHS and in social care.

That said, and I think it may have been prompted by some of your questions at the last hearing I was at, there is clearly an appetite for reform of social care, both in general because of the challenges of the sector, and because of what has been highlighted, as we have discussed before, through the covid issues. I suspect that people from across the political spectrum will increasingly want to see these issues as linked and integrated in the ways that you are describing, but clearly the People Plan itself was about what workforce is needed to deliver the Long Term Plan, which as you know was an NHS plan, not a health and care plan.

Q16 **Mr Mohindra:** Sir Chris, thank you for that answer. Obviously, within the job title of the Department is "Health" and "Social Care", but the People Plan only covered part of the Department. In hindsight, do you think that it should have covered both sides of the Department?

Sir Chris Wormald: Obviously, it is possible to make that case, and something that went wider could have been done, but the explicit purpose of the People Plan was to set out what the workforce needs are to deliver the Long Term Plan, which was an NHS plan with NHS funding and, as you know, did not cover funding for, or reform of, social care, which is being dealt with separately. So, can you make the case that we should have a plan covering the two? Yes, you can, but the explicit purpose of the People Plan was to deliver the workforce required for the Long Term Plan for the NHS.

Q17 **Mr Mohindra:** Obviously my frustration, and I am sure that of others on the Committee, is that the social care aspect of the Department always seems to play second fiddle to the NHS. The reason for my previous question was to see whether there was a battle—or whether a conversation was had—about, actually, a more useful exercise being the pan-system workforce, rather than specific to just the NHS.

Sir Chris Wormald: No, because, as I say, the genesis of the People Plan was about helping to deliver the Long Term Plan for the NHS. I will not argue with the broad case that you make, because clearly that is an arguable proposition. As long as we are in the position where we have

fundamentally different statutory bases for the two services—one a full state-commissioned service, and the other a means-tested, partly privately funded but Government-commissioned in the public sector service—having an integrated plan covering the two is an extremely difficult thing to do. As I say, I think this question is bound up with the wider question of reform of the sectors, but the case you make is of course an honourable case—that you could do a joint thing.

The final thing I would say is that I don't think you should take the fact that successive Governments have traditionally had separate plans for health and social care as signifying one being dominant over the other. It is more a reflection of the very, very different bases of the two services.

Mr Mohindra: I think Sir Bernard Jenkin wanted to come in.

Chair: It's your job to carry on, Mr Mohindra; I'll bring in Sir Bernard in a moment.

Q18 **Mr Mohindra:** Okay. Thank you for that, Sir Chris. Can I move my questioning on to Ruth May? How involved were you in the NHS People Plan, and do you think that the terms of reference for it, as being specific to the NHS, meant that it was a useful exercise?

Ruth May: I was involved in the People Plan. I have been supporting Prerana Issar, who is the SRO for the People Plan, from the very first day she started. We have worked very well as colleagues, and I am sure we will continue to do so. I think your question is whether it should have included social care. One of my reflections from the covid pandemic—not that I would ever want to be in a pandemic at all—is that if anything good can come out of it, that will be the focus on social care and how the integration with social care can be for real. We have a Long Term Plan; we have a long-term funding settlement in the NHS; and we have a workforce plan for our 50,000 additional nurses. So I am well involved in it and I am supporting Prerana.

Q19 **Mr Mohindra:** Looking in from the outside, it looked like the ability to determine the NHS workforce was a lot easier than dealing with the fragmented nature of the social care market. This question is to Sir Chris Wormald. How are you going to make sure that any iteration of the People Plan that incorporates social care actually has the ability to change policy and help staffing levels going forward?

Sir Chris Wormald: There are no plans to change the current basis of the People Plan going forward—just to be clear—but on your wider question, as I think we discussed in the Committee when I was here last time, what we have done in social care during the covid crisis is pushed the boundaries of what we have done nationally, as opposed to the business-as-usual way of running social care, which, as you describe it, is highly fragmented and run by a number of independent providers, commissioned by local authorities. There are yet-to-be-answered questions as to how much of what we have done during the covid crisis we wish to maintain, in terms of our national oversight and national intervention in social care, but it would seem to me unlikely that everyone is going to return to, in

quotes, "normal" at the point where covid is behind us. Quite how far that will go is a matter for decisions yet to be taken, but we will certainly be wanting to look at what we have learned about social care during covid and baking that into future policy.

Q20 **Mr Mohindra:** Could I go back to the People Plan? Prerana Issar, covid has dramatically affected what the new normal may look like. How has that affected the numbers of staff in nursing that we need going forward? Has the exercise been undertaken on your report to actually amend the workforce plan?

Prerana Issar: Thank you, Councillor Mohindra.

At the end of last year, our systems were working to create their strategic plans. That included self-planning, financial planning and workforce planning, from 2019-20 to 2023-24, to be able to deliver the Long Term Plan. These were not published; they are public on some of their websites. But at the end of January, the covid pandemic and the emergency were declared, and since then, of course, it has been all hands on deck to be able to respond to the first phase. Currently, the plans for winter are being worked on.

So, absolutely, the plans need to be revised quite substantially. The first aspect is to bring back the elective work that was stood down to create capacity, as well as bringing back some of the non-urgent care that was stood down as well, as well as preparing for surge capacity that might be needed to respond to potential covid scenarios over the winter period.

All systems are working on their strategic plans, which include workforce planning. The People Plan is ready to be published as soon as possible, in two parts. One of them is really about creating the support that our staff need. They have worked incredibly hard, but they were working incredibly hard before covid. However, during the response to the pandemic, they have worked incredibly hard and we have provided enhanced health and wellbeing support. Some of the aspects of the interim People Plan have been accelerated and we want to make sure that those aspects are not rolled back and instead are actually captured in a plan that focused on culture, in making sure that people can stay and stay well.

Then, a second version will have more of the supply numbers for workforce that are linked to a multi-year funding settlement. As you know, we have not had one in the last year, and therefore we want to make sure that we at least focus on the culture aspects, and then link the revised planning towards the end of the year with when the spending review takes place.

Q21 **Mr Mohindra:** If I heard that correctly, we expect those reports to come to us, or to be published, before the end of the year.

Prerana Issar: The plan on culture, which will be focused on support to our staff and helping to make the NHS a better place—the best place—to work, and improving our leadership culture, as well as capturing some of the service innovations that have taken place in the last three or four

months—early learnings, of course, because we will be capturing some of the service innovations over the coming months as well—that is as soon as possible and certainly before the autumn.

A second tranche will be more about our workforce numbers and linked to a spending review, so it depends on when a spending review takes place.

Q22 **Mr Mohindra:** In terms of the numbers aspect, I think that report is actually overdue, so why is there a further delay? Why does it need to be linked with the spending review?

Prerana Issar: The link with the spending review is that investments in supply especially need to be predicated on a multi-year view and for that we need multi-year spending commitments. We had the election at the end of last year, which pushed the report further out, and it was then pushed further out by the response to covid and the fact that we need to revise substantially workforce plans.

Having said that, the NAO Report and the focus on additional nurses remains. It was a priority in the interim People Plan last year, when it was published in June, and it remains a priority today and going forward as well.

Q23 **Mr Mohindra:** The reason for the questions is that we have had a lot of things move on from June last year, and as a Committee we need to be able to support Sir Chris Wormald in getting staffing numbers to the level he needs, but at the moment we are unsighted on what that number may be. I think Lee McDonough wants to come in.

Lee McDonough: Just to build on what Prerana has been setting out for the People Plan, we have, of course, the commitment to 50,000 extra nurses, which was a manifesto commitment from earlier in the year. The People Plan runs alongside that, but the 50,000 nurses came on top of that. Overall, this is in the context of a Long Term Plan commitment that said its aim was to get vacancy rates down to 5% by 2028. That was set out in the Long Term Plan. The 50,000 nurse commitment—I can talk in more detail about it if that would be helpful—is going to be a substantial down payment on achieving that overall ambition by 2028.

Q24 **Mr Mohindra:** The reason for my line of questioning is that covid has meant that we have done things significantly differently from the way we have historically. My own acute hospital now has a 1,000-bed virtual hospital, which means staffing on the back of that is fundamentally changed. Maybe this question is for Sir Chris, but how have we adapted the People Plan, or how are we going to adapt it, to reflect that significant change in circumstance?

Sir Chris Wormald: I think that is actually for Prerana.

Prerana Issar: I am happy to take that. It is about how service planning, and the demand that is foreseen for the coming months and years, is translated into both financial and workforce implications. At the end of last year, we had systems ready with the workforce plans for the next four or five years, but the context has changed, as you say, so substantially that

they need to completely revise that. Obviously, planning is taking place for different time horizons on a daily basis, from planning shifts to planning weeks in advance, but the kind of time horizon we were seeing in December, which was for the next three or four years, is not possible at this time. The focus is on the winter planning and therefore the document we want to publish as soon as possible is more focused on culture, because we want to ensure that we are supporting our staff. I am happy to share some of the elements of that plan in terms of enhanced health and wellbeing culture and leadership. Beyond winter, once we are clear what the longer-term impacts of covid are on service levels, a corresponding workforce plan can be published.

Q25 **Mr Mohindra:** I know my colleague Ms Blake will talk a lot more about the health and wellbeing of nursing, which is obviously a priority for this Committee. I do not want to steal her thunder. My final question is to Ruth May. There has been a shift to nursing associates—has it worked?

Ruth May: Thank you very much for the question. Nursing associates are a very welcome part of our team. They provide a bridge between a healthcare assistant and a graduate registered nurse. I am very keen to ensure that the graduate nursing workforce is the bedrock of our profession, supported by the other very valuable members of our teams. We know that the 50,000 ambition is for registered nurses, and that is for our graduate nurses.

Q26 **Mr Mohindra:** I heard the numbers. Does it work, and, in hindsight, should we have done something different?

Ruth May: Does it work? Nursing associates are very valuable, and I very much appreciate them. They certainly build a bridge between a healthcare assistant and a graduate nurse. I am also very supportive of increasing our graduate nursing supply, and that is why I am particularly pleased with the 50,000 ambition. I think Lee McDonough is indicating that she wants to come in on nursing associates, if you would let her, and Mark is also *[Inaudible.]*.

Q27 **Chair:** It is a very popular point. Lee McDonough and then I have Dr Radford. We can't have everybody on everything, so if you could be quick, that would be good.

Lee McDonough: We are very passionate about nursing associates for two reasons. One is that they widen access to the nursing profession. As we have said, to be a registered nurse, as a first step you can take a two-year approach to becoming a nursing associate, which is a regulated profession, and then if you choose to, you can go on to do a further two years of study while you are working to become a registered nurse. We are keen to grow that pipeline. The numbers at the start were looking very healthy. We had an ambition to deliver 5,000 and then 7,500. That has been knocked slightly off track, because the intake in March was significantly reduced, but we are hoping that we will catch up on numbers in September. My view is that it is working and they are a valuable addition, for both of the reasons I said—in widening access, and in and of themselves as a regulated profession.

Chair: Dr Radford, did you want to come in briefly?

Professor Mark Radford: Thanks, Chair. Lee has answered exactly what I was going to say.

Q28 **Chair:** Unity across the team. Thank you very much, Mr Mohindra.

Sir Chris, I want to go back to the answers that you were giving to Mr Mohindra on social care. You have been in front of us when we were looking at planning for the social care workforce—the market over which you have strategic oversight at the Department for Health and Social Care. If you remember, we found then that there was not a very clear plan—I summarise our reports. We then looked at the supply of medicines and clinical supplies, particularly in the event of a no-deal Brexit. There was a very clear strategic plan for the NHS, but it was certainly wanting in the social care sector. Now we have seen what has happened with covid, the supply of PPE and so on.

As Mr Mohindra was saying, why are you not looking at it in the round? You have given us a lot of answers about why that is difficult, yet this has been within your Department's purview for some years now. What is the problem? Why can't the Department get a grip on the challenges in the social care market? We recognise that it is different. Is that the problem—you can't cope with something where there is no command and control?

Sir Chris Wormald: I don't really have an answer other than the one that I have already given. Our powers and influence in the social care space are completely different from what they are on the NHS side. That is a fact of life.

Q29 **Chair:** Sir Chris, we have had your colleague in who is responsible for looking at the social care market, and they put a very good case forward about training social care staff and promoting that among nurses and other social care staff, and yet we still have a shortage of people in that sector and challenges with supplies. We are seeing the problems repeat themselves. Surely your Department should have got a grip by now and found a different way of solving this, given that it is still a problem.

Sir Chris Wormald: It is a problem on both sides of the house. What is am saying is that the types of solution that we need to use are very different for the statutory frameworks in the two sectors. As it happens—I was looking at these numbers earlier—if you look at nursing in the NHS and in social care, the vacancy rate is pretty much identical. It is not the case that we benefit one and not the other. In terms of the supply of the workforce, it is the same route into social care nursing as it is into NHS nursing. In terms of what we are talking about today, our interventions, which will hopefully improve the number of people coming into nursing, ought to benefit both sectors, not just the NHS. It is just a fact of life that, under the current statutory framework, we work in social care mainly through influence over bodies, both in the independent sector and the local government sector, whereas in the NHS, as you say, we have a lot more direct levers. That is not the same as saying that we don't have a focus on social care.

Q30 **Chair:** We agree that you have different levers—that is not at issue—but while there are still challenges in the NHS, there are enormous challenges in social care. You seem to be suggesting that the answer is a purely political one—we need a different approach to how we manage social care. That is not for this Committee to decide or discuss. In the meantime, your Department has oversight of this sector, and we have a shortage of staff. You may remember that the Member for Chichester was a member this Committee, and in her area there was relatively no unemployment. Now things are obviously different, but then it was very hard to recruit social care staff, yet the Department's attitude was, "Well, that's the market." If this is an issue that causes problems to the NHS, there must be a way through it. You haven't given us answers today about how you are going to do that.

Sir Chris Wormald: No, I am afraid I don't accept the premise of your question. Our attitude is not, "That's just the market." As you know, and as we have discussed in previous hearings, we take a whole series of actions in the social care space. They are different from what we can do in the NHS, but that is not the same as being inactive.

For the issue we are here to discuss today, the solutions are very, very similar. What we see is, if we increase the numbers going into nurse training generally,

that benefits both the NHS and the social care sector, which face similar workforce challenges. In the particular case that we are here to discuss, interventions to, as I say, hopefully increase nurse supply should improve the situation for both the NHS and the social care sector.

Q31 **Sir Bernard Jenkin:** I think that is all progress compared with where we were a few years ago—

Chair: When you say "progress", Sir Bernard, on which bit in particular do you think there has been progress?

Sir Bernard Jenkin: Well, a few years ago, there was no data about the nursing shortage across the piece; it was all left to trusts. There is more understanding that there is a shared responsibility at the centre, and we have data. For a period, I gather that the Royal College of Nursing could get data only by FOI-ing individual trusts, which seemed to reflect the extreme level of delegated responsibility that we had inherited. We are trying to grapple with that now. So, Sir Chris, I am not trying to hold you directly responsible for the outcomes that we are enjoying at the moment in terms of shortages, but the question is, can we speed up what we do? Who is now in charge of data collection across the NHS for the shortage of nursing staff?

Sir Chris Wormald: The vast majority of our data, including most of our workforce data, comes from NHS Digital. As you say, our data position has improved over the last few years and we have been taking a much more centralised approach to a number of those issues. In terms of knowing which nurses are where and the numbers we need, I do not think that is really our challenge now. The question is getting the numbers heading in

the right direction, in terms of overall nurse numbers and retention, and in terms of the number of individuals coming into the pipeline through the various routes that we have described. I do not think that measuring how many we have is our current challenge; it is how we get our vacancy rate, as Lee was describing, down from its current falling, but still too high, rate of just under 10% to a much more sustainable 5%, as set out in the Long Term Plan.

Q32 **Sir Bernard Jenkin:** Is that vacancy rate uniform across country or does it vary? Are there shortages of specialities in different parts of the country?

Sir Chris Wormald: Both of those vary, and I might ask Prerana to comment on the variability, but you are absolutely right that there are some quite big variabilities, as set out in the NAO Report, in particular specialisms that we need to deal with, and geographical variation.

Q33 **Sir Bernard Jenkin:** Before I come to Prerana, you seem to be saying that the global figure is your responsibility, but the detail is for NHS England. Is that correct?

Sir Chris Wormald: Clearly, as the NAO Report sets out, there are several organisations that share responsibility for nurses overall. The way we manage that, because it is disaggregated in the way that you know, is that we have an overarching board that the Minister of State chairs that brings together all the parties that deal with the issue. Lee McDonough is the SRO for the 50,000 additional nurses. HEE is largely responsible for the training and recruitment side and NHSE&I is responsible for the employer and retention side. The most important thing is how those organisations all work together, and as I hope you are seeing during this hearing, it is actually quite an integrated operation now. NHSE&I signs off the remit for HEE, so there is an agreement at that level, and then people have their individual responsibilities.

Lee McDonough: To follow up on Chris, I am the SRO for the overall 50,000 nurse programme, as he said. We have three main focuses in delivering that overall target: domestic supply, international recruitment, and retention and returners. I can go into more detail about them.

We have acknowledged the point about geographical variation and variation in specialisms. Our training support programme, which was announced as part of the manifesto commitment and will come into force from September, provides an additional 5,000 places for anybody doing a nursing, midwifery or allied health professional degree. On top of that, people are able to access additional amounts, up to £1,000, to take courses that we currently think are under-subscribed, particularly in mental health or learning development.

Chair: We are going quite a long way off Sir Bernard's question, so could we go back to Sir Bernard?

Q34 **Sir Bernard Jenkin:** Can I go back to Sir Chris for a moment? Is the data board the same data board that is accountable for assessing population

need and setting supply growth in relation to population need, or are we just chasing the 50,000 number?

Sir Chris Wormald: There are several points in that. NHS Digital do data collection and are our main source of information about what is happening in the system. The overall requirement for nurses is not set centrally, so individual trusts and other employers decide exactly how many nurses they want to employ individually.

Our commitment is to raise the national total by 50,000—that is set out in the manifesto of the governing party—but the individual requirements for specialisms and what is needed, is done by the process that Prerana described earlier of individual systems and trusts looking at their specific requirements. We then look at the total of those requirements and set the HEE policy and training grant policies, which Lee has just described, to fit with what comes up from individual local participants.

Q35 **Sir Bernard Jenkin:** When can we expect Government to publish a comprehensive set of requirements?

Sir Chris Wormald: That is the second part of the People Plan that Prerana was describing earlier.

Q36 **Sir Bernard Jenkin:** Why are we doing it that way round? You would think you would publish the requirements and then the plan to satisfy the requirements, not the other way around.

Sir Chris Wormald: No, it goes into the process. Prerana might want to add something about the details, because it goes into the process that she was describing. People set their local needs for the workforce. They are then collected, and we put that out into policy, not the other way around. It is not a top-down set of decisions about who would employ who locally; it is done the other way around. Prerana, that is correct, isn't it?

Prerana Issar: It is. The starting point is the demand projection for service and healthcare activity that needs to be provided, obviously within a funding envelope, and then the workforce requirement for that level of *[Inaudible]* and operational planning.

Q37 **Sir Bernard Jenkin:** Okay, but I come back to the point we were raising earlier that it is difficult to plan for the NHS requirement when you are in a market where there are other demands being made upon nursing supply. Unless you understand what demands are being made on nursing supply by other parts of the market, notably social care, then you could be insufficiently planning for what the market actually needs. Nobody in the health sector is going to go in for wholesale nurse recruitment from abroad or wholesale training of nurses, so it really is up to the Government to train and recruit enough nurses for the whole system. Do you have any idea how we can avoid that?

Sir Chris Wormald: Yes, and HEE look across the entire system. I might ask Dr Radford to talk about how HEE do that, but the only thing I would add is that, of course, the NHS is by far the largest part. At the moment, social care has about 36,000 nurses and about 4,000 vacancies. The NHS

full-time equivalent is nearly 300,000, and then there are another 16,000 to 17,000 full-time equivalents in GP land. Of our trainees, when we recruit into universities, approximately 80% of those people then go on to work in the NHS. The other 20% go into social care, primary care or the independent sector, or do not practise as nurses. When we are setting our requirements in higher education, we are looking across the piece, informed by all those numbers. Mark, do you want to describe in more detail how HEE does that?

Professor Mark Radford: You are absolutely right. It is a good question, looking in the round at how nursing works across health and social care. One of the original assessments HEE did in 2017 looked at both health and social care impact in terms of training and education, and Sir Chris is absolutely right: nurses are not just trained in the NHS. Their experience at undergraduate level is across social care and other types of service provision, and once they graduate from university, they then choose to work in either the NHS or other types of provider.

What is really quite critical is, first, understanding from our perspective how many nurses go into that process. Sir Chris has rightly pointed out that the People Plan has been designed around understanding the NHS requirements specifically, but we have always engaged through the People Plan process with a large range of stakeholder organisations within social care and with the Skills for Care organisation to understand the links across in relation to things like placement capacity within social care providers. That is something we are currently working on with social care, including the routes and entry into social care careers and how those two join up.

There is obviously an architecture element to this as well, particularly where we have integrated systems working much more seamlessly between NHS and social care. There is much more work to do, but from our perspective, the workforce is absolutely seen across both spheres. However, as has been identified, the People Plan in the first phase very much focuses on some of the mission-critical challenges that we face within the NHS.

Q38 **Sir Bernard Jenkin:** I have three more questions that I wish to concentrate on. First of all, just to summarise, it seems that a prodigious effort is being made in the Department to co-ordinate NHS England, Health Education England and all the moving parts in order to create a strategy, but the strategy is now being held by the Department. Is that a fair summary?

Sir Chris Wormald: In terms of as we have described it, yes. We own the manifesto commitment, and we seek to co-ordinate the bodies in the way you have described, albeit—

Chair: So the answer is yes.

Sir Chris Wormald: Yes.

Chair: One-word answers can be good.

Q39 **Sir Bernard Jenkin:** The problem you have inherited from the Lansley reforms is that a lot of that departmental capability was stripped out, and you have been subject to the austerity budgets in your departmental overhead. Maybe this is a question for Lee McDonough: how much capacity do you actually have to play this co-ordinating role, or are you too much in the hands of the bodies you are trying to co-ordinate? Should some of the budget for NHS workforce planning go to the Department, rather than these other NHS bodies that are going to look after their own agendas but perhaps not think about the overarching strategy?

Lee McDonough: I have a whole directorate that is focused on workforce, and takes overarching policy responsibility for workforce. There are some reserved functions—NHS pay, for example, and terms and conditions are reserved functions—so we have teams working on that.

As Sir Chris said right at the start, the most important thing is recognising that the whole is greater than the sum of the parts. We have to work together, and the 50,000 programme that I am SRO for is a really good example of what we can do when we do that. Basically, there is commitment from each of the workstream leads: Prerana Issar leads on retention, Ruth May leads on international recruitment and Mark Radford leads on domestic supply, and we work seamlessly together. To me, that is the most important thing, rather than where the boundaries are necessarily joined. We are all very focused on the outcome we have to deliver, and work very closely together.

Q40 **Sir Bernard Jenkin:** That is very positive, thank you. Prerana Issar, how do you decide how much money should be devoted to recruitment and how much directed at retention, and how do you spend money on retention? Obviously, the poor retention rate in the nursing in the health service is one reason that we have a shortage.

Prerana Issar: Thank you, Sir Bernard. It is vital to retain staff. If we look at the Long Term Plan timeframe, most of the staff who will deliver the Long Term Plan are already in the system. Therefore, it is critical that we enable and support people to stay, and for them to stay well. That is a difficult job and it has become even more difficult with covid. We have seen worrying signs of burn-out and anxiety among staff. A *Nursing Times* survey showed 90% of nurses who responded to the survey are feeling higher rates of anxiety than before covid.

Our focus is very much on retention. There were three reasons given in the staff survey. First, staff are feeling the pressure and stress of their intense work. Secondly, there is a lack of flexibility, whether with shifts, balancing caring responsibilities or, towards the end of their career, being able to work in a way that helps to balance other aspects of life. Thirdly, there is the issue of continuous learning and development.

Our retention programme is looking at those three major factors. People are also—rightly—asking for an environment free of discrimination,

bullying and harassment, which is still an issue. We are very focused on that.

As we have seen during covid, some of those aspects do not require additional funding. That was the start of your question, which I want to come back to. For instance, supporting line managers or supporting staff to leave well. In our health and wellbeing support, we have three levels of support: to the individual, to team facilitation and to line managers. We have made a free mental health helpline available to all staff across NHS and social care. We have had more than 6,000 calls to the helpline. We have a text line available as well. That comes through fantastic partnerships with the Samaritans and Hospice UK, etc. There is also some practical support from employers, where they have provided free tea and coffee, especially out of hours.

The best investments, in terms of getting more staff, is retention. It is a valid and important supply intervention. As I said, some of this is part of running as a good employer. There are some things that of course require additional financial investment on the retention side.

Sir Bernard Jenkin: That is a very full answer. Forgive me for stopping you.

Chair: Thank you, Sir Bernard. I will now move to Olivia Blake.

Q41 **Olivia Blake:** These questions are for Ruth May. I am curious, because there seems to be a greater shortage in mental health and learning disabilities, with mental health trusts having much higher vacancy rates at 16%. Do you know why that might be?

Ruth May: Thank you, Ms Blake. I appreciate that question, because mental health and learning disability is an important part of our nursing profession, not just because they are valued colleagues, but because they care for people at the most profound moments of their lives.

In summer 2017, we recognised the need to step up our work on retention, which is why Dr Radford and I led a piece of work in NHS Improvement on our retention collaboratives. We concentrated in wave 1 on mental health, as well as some acute and community services. In wave 1, we wanted to work with all our mental health trusts. That is really important.

I am pleased to say that mental health services made the greatest improvement in retention. Their turnover rates went down from 14.3% to 13.4%. That was better than what we saw in acute.

With all our retention, particularly in mental health, we saw the need to focus on early years and making sure that people were nurtured and supported as soon as they were qualified, and that they were supported with their flexibility as they came to their mid-years. We also wanted to support the more mature of us with their retirement and their return from retirement. I am really pleased that we supported mental health trusts in the way that we did.

Q42 **Olivia Blake:** Is any specific work on recruitment going on? I think that was a useful answer on retention, but is anything happening specifically to get more people wanting to work in mental health?

Ruth May: Absolutely. We focused part of our "We are the NHS" campaign on recruiting in mental health and learning disability. I am very pleased to say that we have 12,000 more nurses than we had at this time last year, and some of them will be for mental health. This time last year, we had 43,000 vacancies in the NHS provider sector, and I am very pleased to say that now we have 36,000. That is still too many, I accept, which is why we are going for the 50,000 ambition.

There is loads of work happening in mental health. Of course, if you want more detail on students, the student support package offers £5,000 to £8,000 starting from this September—£5,000 for everyone and £1,000 for learning disability and mental health student nurses because we wanted to encourage them into our sector. There is a wide range of recruitment and retention practices going on in mental health.

Q43 **Olivia Blake:** My next question is about the different pathways and routes of recruitment and retention at the moment. What numbers do you expect over the next five years for those different pathways? That could go to any of you, but I will ask Chris Wormald.

Sir Chris Wormald: Sorry, you broke up a little there. Could you repeat that?

Olivia Blake: Can you give us a breakdown of how many additional nurses you expect to get over five years from the different groups of recruitment and retention?

Sir Chris Wormald: I might ask Lee McDonough to come in on that.

Lee McDonough: To clarify, are you talking specifically about the 50,000?

Olivia Blake: Yes.

Lee McDonough: Thank you for clarifying. Basically, we have three main focuses for achieving the 50,000 target. There is bolstering domestic supply, which we talked about in the training support grant intervention. We are also doing more in relation to post-graduate entry and trying to increase the number of students who come in through that route, as well as some proposals around widening access through the apprenticeship groups. We have the nurse apprenticeships, the nurse associate apprenticeships and offers around a blended degree, which is much more focused on clinical learning with online training. That would launch in January next year and is expected to broaden the base of students further. That is the domestic supply.

In relation to international recruits, we have always had a vibrant intake of people from across the globe into our nursing workforce since the NHS began. We want to carry on and ensure that that continues. Clearly, that has been affected a little by the covid situation, but we have a very

healthy pipeline from our provider side, with people waiting to come over, and further plans to bring more.

The other route is retention, which we have discussed. Broadly speaking, there are those three focuses. In terms of the relative proportion of what will contribute to the overall numbers, we are still refining our plans in the light of covid. Obviously, at the start, when the manifesto commitment was announced by the Government, they set out the proportions, broadly speaking, and we are probably in a similar kind of territory. We would have hoped to have clearer plans by now, but because of covid we are just having to look at the impact to make sure that we can see the relative proportions.

Professor Mark Radford: In support of Lee, the programme board is really critical in terms of our delivery against the 50,000, but of course the elements underpinning that are flexible and we have to be dynamic in the planning process. You rightly pointed out some of the challenges that we face in international recruitment. When we were planning last year, I don't think many of us were expecting the global pandemic that has now hit, so of course the plan has changed. Of course that has affected domestic recruitment. In our planning phases last year we were looking at between 4% and 6% growth. We have had quite a phenomenal response this year in terms of domestic applications to nursing courses. As you will have seen from the recent UCAS data, they are now up 15% against nursing applicants for this September, so our plan has now dynamically changed as a result.

We are aiming to maximise greater gains this September through the domestic supply agenda. I know that Ruth and others, with Lee and the rest of the team, are really focusing in on what that means for international markets. Of course, as Prerana has rightly described, that does not mean that retention is delayed either. All of the work post-covid and intra-covid now becomes mission-critical to do that. While the 50,000 is an aggregate plan, underneath that sits a very dynamic set of assumptions and planning delivery to ensure that we are able to maximise on some where we have seen gains, like domestic supply, or revise our plans—particularly in areas such as international recruitment, where they may be delayed slightly because of issues to do with the global pandemic.

Q44 **Olivia Blake:** I recognise this is very difficult at the moment, given the crisis we are in, but how quickly will we know how effective nursing apprenticeships and associates are, and if they are actually value for money compared with the other ways of getting nurses?

Professor Mark Radford: Absolutely; the apprentice route is one mechanism and an entry route into the graduate nursing profession. Of course, the traditional graduate route may not be ideal for many people, so having the apprentice options—yes, in some cases they are more expensive than other routes into a graduate role, but one has to recognise that there is a differential in terms of both costs and the person's ability to earn while they are doing their training and education, which, again, is another critical element.

Also, there is the issue of the fees and costs associated with that individual going on. It provides an access route in. We need to open up all routes into nursing to ensure that we still have those people who are entering the graduate profession. For some people, the learning style of a 2 plus 2 model—starting as a nursing associate, and then going on to do the conversion course into registered nursing—does allow them to have a step and a gap in the middle. They can earn; they can continue to support the NHS before making their decision to go on further.

There are obviously huge differentials in the numbers that go into those routes, depending on the marketing and the approach taken. There is a cost differential between each of those elements. Some of that sits with the employer, some of that sits with the university and some of that sits with the student. But of course what we are identifying is the flexibility. We have a two-year postgraduate programme, which is for those who have got an initial graduate degree going into nursing, and accelerated—two years. We obviously have a traditional three-year graduate degree programme. Then there are two or three options from an apprentice route, through from nursing associate, assistant practitioners and other route entries into other types of graduate role. I think all of those are needed to provide the wide range of possibilities and support for individuals, depending on which route and what point they are in terms of their own education.

Q45 **Olivia Blake:** I think the point I am trying to get at, Dr Radford, is: has the focus been too much on extra routes rather than increasing nursing numbers, and how will we know that these extra routes are actually achieving, when we have got a crisis in recruitment?

Professor Mark Radford: As an example, if we look at the graduate nursing route, since 2017 that has been through the loans-based system led by the HEIs, so, yes, we have seen a reduction in the number of graduates coming through initial nursing programmes. That trend does seem to be reversing. We have seen early gains last year and this year in terms of the additional growth, but offsetting that has always been a plan to boost the number of postgraduate numbers coming through, and also other apprentice models, to be able to support people through different training approaches.

With the apprentice models, we can see relatively early gains. As Lee McDonough has identified, the nursing associates have seen 5,000 and just under 7,000 people enter those programmes. Of course our primary aim with the 50,000 is registered graduate nurses. These are entry routes into that, and now we are focused on domestic supply, particularly with the graduate and the postgraduate routes.

Q46 **Olivia Blake:** Can I ask why other alternatives were not looked at? Access courses would be a traditional way to get widened participation. Why have you not opened a new programme?

Professor Mark Radford: Access courses have been led in some cases by further education, which is a really good opportunity. Some universities

run their own access course for degree programmes, but with the nursing associate and assistant practitioner roles, it means that they can learn while they are actually earning a salary—again, that is a really important differential. It also allows them to step off after two years with a qualification. In the case of the nursing associate, it is a registerable qualification that allows them to work in the service before they make a decision to go on to become a graduate nurse, if that is what they wish to do. There are a range of opportunities, both through access routes and through early years career training opportunities. Importantly, there is also a step-through opportunity to go on to be a graduate nurse. I don't think we have excluded any; I do think we have used many different options to support individuals with different learning requirements through to that process.

Q47 **Olivia Blake:** What happens if trusts do not create roles that are appropriate for nursing associates at the level to which they have been trained? Do you think that would lead to people not going on to become nurses? Is that a concern at all, and how are you encouraging trusts to do that?

Professor Mark Radford: We always had two waves of nursing associate programmes, and they were really about testing out the new profession within different organisations—different routes and recruitment. Many of our initial wave trusts had then gone on to have full nursing associate programmes. Other organisations have developed assistant and associate practitioner programmes as well, which are another route through training and education, but, importantly, most of these routes go through the apprenticeship model. Some of the organisations have found it a challenge to be able to deliver the scale of these types of programmes, but many have been very successful in terms of their development. We know that some of the challenges for our provider organisations have been around the ability to scale up a large number of apprenticeships and access some of the levy opportunities, but we continue to work directly with trusts and, of course, with the Department too. We try to be as flexible as we can around the apprentice routes while, again, keeping a real focus on undergraduate domestic supply.

Q48 **Olivia Blake:** To me, these sound like good initiatives to get people in, but it takes time to train them. You might get an issue with confidence between apprentices and associates, who might want to work for a number of years before they go on to become fully qualified nurses. How are you planning for that? How are you going to make quick wins on this and make sure that we are getting the nurses in the pipeline earlier, and how are we going to deliver in the next five years?

Lee McDonough: Without a doubt, you are right: some of these apprenticeship routes do take longer. I still think it is the right thing to do, for the reasons we have said. Just to be clear, our main focus is on the big supply route, which is the undergraduate market, and on expanding that. That is why the investment in the training support grant is so material, to incentivise people to take up that route. As Mark said, we have seen a

really positive response so far, with a significant increase in the number of unique applications that we have received already, in advance of clearing.

You will be aware that there has been a process across all courses to look at making sure the numbers are capped in a way that stabilises the market. Within that overall approach set out by DfE, we have secured an additional 5,000-place ring fence on top of provider plans plus 5%. The bidding process for those places ended on Friday, and I am delighted to say that, actually, we were overbid. There were more than 5,000 bids, and we have been assured by DfE that we will be able to meet that demand. Coupled with that is the agreement we have got. We have a real focus on clinical placements, which is the other side of the equation. We have 30,000 clinical placements with funding for that. I think that a combination of the training support and assurance on the clinical placement side for providers has given them confidence to step up and increase their intake. So I think it is looking very encouraging. We are really hoping that we will get an ambitious step up in September.

Professor Mark Radford: To answer the question from Ms Blake, as part of the 50,000 programme we have a very specific programme directly targeting and supporting nursing associates and assistant practitioners in their conversion, which is absolutely about writing and supporting them to develop a personal development plan so that we can be really clear, when they enter that programme, that there is a real opportunity and a plan for those who wish to do so to step into registered training as and when they wish. That has a very clear project delivery over the next 12 to 18 months to ensure that we can support those individuals if they wish to progress on to registered nurse training.

Q49 **Olivia Blake:** Obviously, we are at a very difficult point at the moment with very slow progress, but what are you doing to make sure that the gap between nursing supply and demand does not continue to grow and it does not happen again in 10 years' time?

Chair: Who is that question to, Ms Blake?

Olivia Blake: Chris.

Sir Chris Wormald: It could have been a question to all of us. As my colleagues have described, at this moment in time the vacancy rate is falling and our application rate in higher education is going up. At this moment both our primary indicators are looking more encouraging than they have in recent years. The challenge, exactly as the question says, is to keep it that way. Key to that will be achieving the 50,000 additional nurses as has been described, but also—to go exactly with your question—having a clear long-term aim. It was described earlier in this hearing that 50,000 is a down payment on trying to get the vacancy rate for nursing down around 5% by 2028 as set out in the Long Term Plan. That is the number we all think is a sustainable level that allows turnover while not having too much pressure on the system. The answer to your question is: always have a long-term goal like that. I think it probably is true that at points there has been too much hand to mouth in this area. Having that

long-term objective, and sustaining having a long-term objective as set out in the Long Term Plan is the way—

Chair: We have had the People Plan and long-term objectives, but—it seems to be not for comment rather than for you to be drawn on—different manifestos of different parties at different times promise numbers, and that then becomes the target. That does not seem very long-term sustainable, but I will leave that hanging.

Sir Chris Wormald: I will not comment on the party politics, as you say. Nevertheless, being in a situation where we have a long-term target and we have our primary indicators going in the right direction, if we all coalesce around those things and if all those things are right, then the future looks better for nursing supply.

Chair: Sometimes I wonder whether that is luck rather than judgment. That is not a criticism, in this case, of the Department. We politicians sometimes have something to answer for.

Q50 **Sir Bernard Jenkin:** On this question of retention, I wonder if as much attention is given as it should be to the quality of leadership in the various parts of the NHS. Very often, inspirational leaders will inspire loyalty despite tough working conditions or lack of pay. The feedback we get from the nursing profession is that people leave because of poor leadership, poor support from managers and leaders, a lack of understanding and empathy from managers and leaders, and bad working conditions, bluntly.

Ruth May: Leadership is absolutely important. It is key, and at every level. I am very confident in the leadership of directors of nursing in putting the nursing workforce at the top of their agenda. But you are also right, Sir Bernard, that it is your line manager, whether you are a matron or a community team leader, who has the biggest impact on your success and wellbeing at work. That is why the People Plan is concentrating very much on health and wellbeing at work. That is why our retention collaborative focused particularly on supporting people at work at the level that they are doing it. It is right to say that leadership is vital all the way through the NHS and care, to support and to keep our staff.

Sir Chris Wormald: Not that much to add, but—

Chair: That's fine; you do not need to add anything. We have heard from the chief nurse.

Sir Chris Wormald: The things we went through earlier on how to improve the culture are all aspects of great leadership—*[Inaudible.]*

Q51 **Chair:** May I suggest, while you do have something to say on this, Sir Chris, we are keen to hear from the chief nurse, because she speaks for the nursing profession? I am going to go to Prerana Issar on this point as well.

Prerana Issar: I wanted to highlight a few actions that we are working on to support leaders. Personally, coming from outside the NHS—I was at the United Nations for six years and before that the private sector—I have to say that the NHS has some incredible leaders, the best in the world. I say that with a lot of grounds for comparison. Having said that, there is also a great deal of variability; it is a complex job that people have to deliver on, and we should be providing all the support we possibly can.

In order to do that, we have the leadership academy in NHSE&I, which is working on clinical leadership, with the Faculty of Medical Leadership and Management, to expand the number of placements for talented clinical leaders. Somebody said to me just last week, "I'm a consultant radiologist, but nobody has told me how to lead a team. I am a very good radiologist, but I also want to be a very good leader." We are working on that with the Faculty of Medical Leadership and Management.

Two more things: all the material on leadership that we were delivering in person will be made virtual. We were already moving in that direction, but covid has accelerated that, so we will be able to reach a lot more people. Also, every line manager in the NHS will have access to line management training, with action learning as a key component, before the end of the '20-21 financial year. This is a huge area of focus for us and, with the very difficult jobs and the incredible amount of responsibility that leaders and managers in the NHS have, we want to support them as much as possible.

Q52 **Sir Geoffrey Clifton-Brown:** I will stick with Prerana, if I may. To what extent, in terms of retention, is work-life balance a problem? It was a problem before covid; is it an even greater problem since covid?

Prerana Issar: The staff were working incredibly hard before covid, as you say, and the pressure has been incredible during covid. It has been very difficult. The rapid service innovations and the quality of care that was provided before and during have taken a toll on people. I want to answer the question in a couple of different ways. One is that work-life balance is a very individual, personal definition: in order to support people to have what they define as work-life balance, it is important that it is an individual conversation for people, depending on their life situation, family, home life and the type of work they are doing. So we have a lot of learnings from the health and wellbeing work we have been doing at both a national and a local level, and we are seeing that people want support at work, but they also want support as a whole person. For instance, we have offered financial advice to people—our helpline has financial advice based on the kind of stressors that people are experiencing. We have bereavement support because, tragically, people have lost loved ones and family and friends. Local trusts—of course, it is employers who make the work-life balance possible—have done a lot to support people, whether it is a leaving well checklist or wobble rooms where people can talk about their days so that they are able to leave well and leave their work at work.

We also know that people are not able to leave their shift on time; they have to do hours beyond that. Some of the service innovations have actually helped people to have that balance a bit more, whether it is use of

technology—people have said bureaucracy has decreased, and for people in primary care and others who can work remotely from home, that has provided a better work-life balance than they had before. We want to make sure we capture some of these changes and not let them slide away.

The one last thing I want to add is that there is this covid marathon, which we are trying to frame as a series of sprints, and between sprints—before winter starts—people do need to rest. Because NHS staff and care staff give a lot of themselves and do not put their own wellbeing first, or even second or third, we are helping managers and staff to ensure that people are getting some rest and recovery in between sprints. We hope that they are able to do that before the pressures of winter.

Q53 **Sir Geoffrey Clifton-Brown:** Prerana, I want to stick with you. With your United Nations experience, do you think we are right to concentrate so heavily in the UK nursing sector on recruiting nurses from abroad? Are we in fact taking great expertise from poor countries that desperately need those nurses in their own national health systems? Should we be doing more to recruit a greater percentage of nurses from the UK population?

Prerana Issar: I would say that, as my colleague Mark said, the most sustainable route is expanding domestic supply. Having seen the public appreciation of what the NHS does and what NHS nurses do, that is absolutely where we should focus. However, there is value in having an earn, learn and return programme, as we have been running with certain countries, where there is a Government-to-Government MoU, because actually that is a win-win situation where skills are built and then taken to countries. We have a list from DFID of countries we are recruiting from, so it is not anywhere in the world; we absolutely want to recruit internationally in an ethical and responsible way. Ruth may want to come in as the SRO on international recruitment.

Ruth May: International recruitment has to complement domestic recruitment. We cannot just concentrate on one or the other. Our international colleagues have been very valued members of our workforce for many years, since the inception of the NHS. Equally, they work alongside our domestic recruitment ambitions.

We will work in line with the World Health Organisation's code of practice, which lists the 43 countries that we are not to recruit from, and we will not. There are two states in India from which we will not recruit because of this. That is the right, proper thing to do. But we will want to recruit across the globe. That needs to be to enhance our workforce so that we can all work together and learn from each other, because people coming together from diverse backgrounds provides safer care.

Q54 **Sir Geoffrey Clifton-Brown:** I will stick with you, Ruth May. It has always seemed strange to me that the NHS invests a great deal of money in training a nurse who can go straight off to the private sector or wherever. Should there be some form of tie, with a person having to remain an NHS nurse for a short period so that they repay in work the

training that the NHS has given them?

Ruth May: It is important that we make sure that people want to stay in the NHS for the right reasons—because they get great clinical care, and they will work with amazing institutions and colleagues. That is why I was really pleased to see £150 million going into continual professional development last year. From this finance year, trusts have already got some of that money and can support frontline nurses in continuing their development. We know that that attracts people and helps them to stay. No, I do not think there should be a tie. With Prerana, the chief people officer, I want to make it an NHS that people want to stay in. That is our ambition.

Sir Geoffrey Clifton-Brown: Thank you very much. We are very grateful to everybody who has worked so hard during covid to keep us safe.

Chair: The whole Committee backs that up.

Q55 **Olivia Blake:** I really want to get underneath the overseas issue. What progress have you made so far this year in increasing recruitment?

Ruth May: Of course, we have had a lockdown and travel restrictions in place, so it is going to be more of a delayed start than we wanted. However, providers told us only last month that they have over 6,000 nurses in overseas countries who are willing to come and work, and who want to come and work in England. I am delighted that that is going to be the case. Interestingly, even last week, we had 23 nurses arrive in the UK from India to go to Sheffield. I think we will start seeing this open up very rapidly. It has just been a slow start because of the covid travel restrictions.

Q56 **Olivia Blake:** What update can you give us on the introduction of the NHS visa, which was announced last year? That is to Sir Chris Wormald, I guess.

Sir Chris Wormald: Actually, Lee McDonough.

Lee McDonough: The health and care visa has been agreed, and is a 50% discount for people coming in, compared with the normal visa cost. That means that the price is about £200-plus for a visa that gives you leave to remain for less than three years, and about £400-plus for leave to remain beyond the three-year period. That is half the cost that other people will pay. The other addition, which is really important, is that the Prime Minister announced recently that people coming to work in the health and care sector will be exempt from paying the immigration health surcharge. Again, that is a significant saving for people. That is a charge to allow people coming into the country to access free healthcare. Our colleagues who are coming to work in the care and health system are exempt from that.

Q57 **Olivia Blake:** What conversations have you had with the Home Office on the new points system?

Lee McDonough: We worked with the Home Office to make sure our views were fed in. We provided input into the MAC process, in terms of looking at the overall requirements for healthcare workers. Our views are fed into the overall process.

Q58 **Olivia Blake:** Do you think they were successfully heard?

Lee McDonough: In terms of access through the tier 2 system, yes I do. Qualified professionals who are coming to work in health and care will be included and will have access through the new points system.

Q59 **Olivia Blake:** The HEE-led global learners programme has missed its targets for 2018-19. There has been a significant increase on that, of 15,000 by 2024. Do you think that is too ambitious a target, and do you think it can deliver?

Lee McDonough: Could I hand that to Mark Radford, who leads that?

Professor Mark Radford: Thanks, Ms Blake. The HEE global programme has many facets to it. It works internationally around training and educating, and supporting rotations, for example. It also now has, in the past couple of years, a recruitment arm, which was initially focused on our medical staff, but more recently has focused on nursing. We are doing that completely in partnership with the Department of Health and Social Care, as well as NHS England and NHS Improvement.

Last year, yes, they were shy of what they set out to achieve. They spent a great deal of time at inter-Government level, supporting new arrangements, as you rightly pointed out, on ethical recruitment approaches and approving programmes to support recruitment over in India, the Philippines and other countries.

The challenge, as Ruth May rightly identified, is making sure that when those colleagues arrive in the UK, they are supported directly into our provider organisations or social care. That is very critical: the tie-up between the global programme, and the NHS and, importantly, the system—so including those colleagues who might step into social care, which is critical. So, no, I think the ambition to recruit larger numbers of overseas nurses, with the experience of the global team internationally, as well as the delivery and support of the DHSE, is absolutely right and critical.

As Lee McDonough, Ruth and Prerana have all articulated, however, we are absolutely focused on domestic supply security, which means that in the medium to long term, we should be aiming towards delivering most of our health and social care need for nurses from domestic supply and, importantly, still keeping the NHS and social care open for learning and educational opportunities for international partners and, also importantly, still welcoming any international colleagues who wish to work in the NHS and social care, not only for the rich opportunities that they will learn from us but, importantly, for the learning opportunities that they will bring from their home countries to our health service.

Q60 **Olivia Blake:** I think you are right: this is an international issue and, in a sense, an international shortage. Do you think that pay in the UK is internationally competitive enough, given that people can earn double in Australia and a third more in Canada? What impact do you think that that will have in the long term, on home taught and international nurses?

Professor Mark Radford: My colleagues have absolutely recognised that there are many issues of recruitment and retention, and pay is one of them but, importantly, we need to address a range of other areas: Prerana rightly identified health and wellbeing, and there were the comments on leadership support, and development and CPD. All of those are, rightly, also important attractors for colleagues who come from overseas wanting to work in the NHS.

We cannot get away from the fact that there are pay differentials across the globe but, importantly, there are very different structures and markets. You recognised the Australian market, and there is also the middle eastern versus the USA markets, which are able to deal with recruitment through use of pay to a far greater degree than we are able to here in the UK.

Q61 **Olivia Blake:** I will move on to Ruth May and your assessment. Basically, we discussed the welfare of nurses—you mentioned the 90% anxiety in our earlier discussion—but what assessment have you made of the impact that that will have? Will there be a post-crisis drop-off, in particular when taking into account the fact that more than a third of the workforce are aged over 55? How do you plan to measure and cope with that? Can we pre-empt it?

Ruth May: You are right that this has been a very challenging time for all our frontline staff healthcare workers, but particularly nurses, and that is what we are here today to discuss. It has been the most challenging time of my career. It is a global health emergency, so it is the same for frontline staff.

We have done this before, though, in some ways. We have had retention work in which we have supported people, and we have made real differences—a 0.5% reduction in the leaver rate—and that is significant. We will need to continue to do that.

You have also heard Chief People Officer Prerana Issar talk about the soon-to-be-published People Plan, which will set out what she talked about, such as the wellbeing and support offer that we have for staff. But we are going to have to do all this together. The RCN survey came out over the weekend and said that as well. So I hear it; I acknowledge it. We have form for delivering and we have form for absolutely working together to improve the lives of nurses; and we need to do that again and again, to make sure that our nurses are supported as much as is humanly possible.

Q62 **Olivia Blake:** I am aware that burn-out is a big issue and one that people are very concerned about. I am just referencing the Royal College of Nursing employment survey: 23% of the nurses said that they had another job on top of their main one—55% of them were doing bank

nursing, 23% were working through an agency and 17% were doing additional hours. Do you think that this is a coincidence or that it is showing that there is not enough reward in the system?

Ruth May: We know that, during this global emergency, nurses—all NHS staff—have worked extra hours. This applies to lots of people. Whenever I have been talking to nurses, when I have—rarely—been working shifts alongside them and whenever I have been doing visits, everybody has said they will work extra hours—

Chair: Sorry, Ms May, I don't think Ms Blake was talking about the current crisis.

Olivia Blake: No—apologies—I was referring to a 2019 survey and the wider issue of whether you think that reward is high enough, because a quarter of the staff are taking on additional hours or jobs.

Chair: Can you just source the survey, Ms Blake? Can you explain which survey it is?

Olivia Blake: It is the "Royal College of Nursing Employment Survey 2019".

Chair: So the regular RCN survey. It is not an NAO-authorised document, but that's fine.

Ruth May: We know that pay is an important issue with regard to nurses. Indeed, in this weekend's survey from the RCN, that comes out as well. I support nurses being properly rewarded. Why wouldn't I? I'm the chief nursing officer for England and I want to see the nursing profession and every member of our nursing profession being properly rewarded.

Q63 **Olivia Blake:** Do you think the pay cap has had an impact on retention, and if not, why not?

Ruth May: I said well before I was chief nursing officer that I believed that the lack of pay rises that the NHS staff saw for a number of years during the austerity measures did have an impact on retention. We know that that was the case with increased numbers of nurses going to work through agencies. We have seen some of that reverse. I am delighted to see 12,000 more nurses now working in the NHS. It doesn't need saying that of course I want to see nurses being properly rewarded, but with regard to pay, there will be colleagues from the Department of Health and Social Care who may want to talk further around pay.

Q64 **Olivia Blake:** Do you think there are any lessons about flexible working from the covid-19 outbreak that would help to keep nurses in the NHS?

Ruth May: Absolutely. We have seen with nurses in all settings—whether it's a community nurse doing online conversations, mental health conversations, whether it's a specialist nurse having online, digital consultations or whether it's people working in other roles and working from home—that flexible working has been key. We have seen that through our work on retention since the summer of 2017. I think that

more flexible working will continue to happen. I don't know whether Mark wants to come in.

Chair: Well, I am in Ms Blake's hands. Ms Blake, if you are happy with that, we may not need to—

Q65 **Olivia Blake:** I am happy with that answer. I just have a final question about the social care market, if that's okay, Chair. What impact will nurses moving into the social care market and dropping out of their NHS pension schemes have on encouraging nurses to go into that sector if there is a shortage?

Ruth May: We would want to make sure—we want to see nurses in all the settings, across all the branches, and that absolutely includes social care. With regards to pensions in particular, I will pass over to Department of Health and Social Care colleagues. As I said earlier, if there is anything to learn from the pandemic, it is about how we have closer integration between health and social care, from my point of view, which therefore includes the workforce.

Chair: That is a whole area that we would like to probe more, but I will move on to James Wild MP, and then to Sir Geoffrey Clifton-Brown.

Q66 **James Wild:** My local acute hospital, the Queen Elizabeth in Kings Lynn, has successfully reduced its vacancy rate to 5%, but to do so, it had to recruit 140 nurses from overseas. You talked about the domestic pipeline. What is the role of the DHSC in supporting trusts to encourage greater local training provision for apprenticeship roles?

Lee McDonough: As we have said, in terms of setting out plans for the 50,000 nurse programme, we have provided the overarching framework that is looking to push on all fronts for domestic supply, for which apprenticeships and local training are key. There has been a whole process. Basically, the role of the Department has been to get the standards for all the different apprenticeship routes cleared through the central processes, and then to work with colleagues in HEE and NHSE&I to make sure that we are encouraging trusts as much as possible to take those routes.

Some of it is about how HEE engages, because obviously they are training posts and there is a need to ensure that they are embedded really well and have the proper support. Some trusts are brilliant at that—for example, Leeds Teaching Hospitals are absolutely fantastic in terms of the range and the number of their apprenticeships—but that is variable across the country. Mark Radford might want to comment on that.

Q67 **James Wild:** The Queen Elizabeth Hospital and the local College of West Anglia have developed proposals to deliver a school of nursing and nursing associate roles for a modest capital investment. Is that the sort of proposition that the Department would fund or support funding from other parts of Government for?

Lee McDonough: We are obviously keen to encourage a range of routes into different places. It is an area that we have talked about how we can

grow the roles and relationships with the further education market. As part of our 50,000 nurse programme, we have looked at how we could encourage HEIs and other institutes to basically invest in those courses. For example, I have been having a discussion with Chichester to look at whether they can expand and increase their nursing programmes.

Chair: So it is the sort of thing that you would consider. We will move on, because of time, to Sir Geoffrey Clifton-Brown.

Q68 **Sir Geoffrey Clifton-Brown:** I will stick with you, Ms McDonough, on the subject of apprenticeships. Paragraph 8 on page 10 of the Report says that the NHS in general used only 30% of their apprenticeship levy, so presumably the other 70% is dead money. What are you doing to step up the recruitment rate for apprenticeships? For example, are you going into schools and colleges to try to sell the idea to youngsters?

Lee McDonough: There are two sides to that question. Yes, we are doing a huge amount through the comms campaigns and the handling campaigns to try to encourage people to come into the health and care system more broadly. In relation to the first part of your question, forgive me—

Sir Geoffrey Clifton-Brown: The apprenticeship levy.

Lee McDonough: I do not think that the figures that relate to the 30% uptake take full account of the proposed spend in terms of nursing associates. When you look at the forward plan in terms of the number of nursing associates and the access to the apprenticeship levy there, it is a much more significant amount of the overall £200 million that comes in from the NHS.

We have recognised, however, that there is more to be done on apprenticeships, as we have said. There are some difficult issues around that. It is not straightforward. Trusts have to put in a bit of extra effort to get really strong apprenticeship programmes under way. That is why I said earlier that some places are really brilliant at that because they have invested and they can see the benefit of it, but there is variability across the country, so there is more work to be done on that.

Q69 **Sir Geoffrey Clifton-Brown:** It does seem to be a good route into nursing, because it does not incur the graduate student loan fee. You go into it without that loan. Are you going to set a target for the number of apprenticeships that you want to draw into NHS nursing?

Chair: Shall we throw that to Dr Mark Radford?

Professor Mark Radford: I think we need to be really clear about the apprentice route and the graduate nursing route. Nursing associates are a separate profession from nursing, and there are boundary differences between what a nursing associate can do versus a registered nurse. The two-year versus the three-year training are fundamentally different in terms of the end product capability. Of course, the 50,000 programme is very much geared towards high-quality graduate nurse education—a

registered nurse qualification. The entry routes to the apprentice routes are feeders into programmes for further nurse training, so they still need to go on to complete their nurse training after this. It is really important to recognise that that widens participation and delivery. Yes, we do have a focus on making sure that we have enough apprentice routes into this, but we need to then ensure that those go into registered nurse training. Importantly, the 50,000 programme is focused on traditional routes of undergraduate and postgraduate supply of registered nurse graduate qualifications. Often the two are seen as interchangeable, but there are boundaries between what those two roles can do.

Q70 **Sir Geoffrey Clifton-Brown:** Given that you have made such an emphasis on the difference between the two systems, and that you have a target for the graduate route, are you going to have a target for the apprentice route?

Professor Mark Radford: We currently do have a target for nursing associate apprenticeship routes. Within that, there is a sub-target for the number of nursing associates that then convert into registered nurse training. Yes, there is—on both levels.

Chair: Thank you. Gagan Mohindra, over to you.

Q71 **Mr Mohindra:** My question is to Sir Chris Wormald. It is to do with the NHS nursing bursary. Can you explain to the Committee what lessons you have learned from that? Obviously, Government policy was to remove the bursary. We saw a drop off in numbers and then we introduced it.

Sir Chris Wormald: Clearly, the switch to loans, which we undertook in the spending review in 2015 and then implemented in 2017, achieved some of its objectives but not others. What we had expected to see with the uncapping of numbers, which the switch allowed, was a much more vibrant market to develop as a result of that change. As the National Audit Office Report very clearly sets out, that did not happen. The design of the new training grant—Lee McDonough may want to add to this—did seek to learn the lessons of those changes, particularly around being much more targeted. It flows, in fact, out of a lot of the issues that have been raised in this hearing about geographical shortages and shortages in specific subjects. We have not sought to recreate the position pre 2015; we have sought to design a programme that, as well as providing general support to the total nurse numbers, is much more specific around the particular areas where we have specific concerns. I don't know whether Lee wants to add anything.

Q72 **Mr Mohindra:** Can I ask for Lee McDonough's views on that?

Lee McDonough: As Chris said, this is an evolution. We are not seeking to reintroduce the capped bursary process, which limited the number of places. We want the market to open up, and we want supply to be incentivised and the HEIs to respond, so that we see a bigger footprint for undergraduate nurses.

To build on what Sir Chris Wormald said, we really tried to look at how we can focus. There are two bits of focus. There are specialisms, which I mentioned earlier—mental health, learning disability and autism—but there is also age. We saw a big drop off in the number of mature students. For these purposes, that is 21 years plus, which does not feel very mature, but they are not people coming straight out of university. We saw quite a significant drop in people applying from that cohort. We are listening to feedback about why and targeting things around them, such as an extra £1,000 for childcare support. Early indications are that we have started to see an increase in the number of people aged 21-plus applying to go into this September's intake.

Q73 **Mr Mohindra:** Do we have any costs associated with stopping the bursary and then reintroducing it? Do we know how much that has cost the system financially?

Lee McDonough: In headline terms, stopping the bursary has saved money that was being spent on the central bursary system from a Department of Health perspective. Obviously, there was an impact in terms of people taking out student loans. I do not have the net difference between those two components in front of me.

Q74 **Mr Mohindra:** Do you mind writing to the Committee about that? There is public health to look at, and the money side of it. We could see what the value for money side of the change in policy meant.

Lee McDonough: I don't know if Chris would like to come in on that.

Q75 **Chair:** As Mr Mohindra has highlighted, it was not that one scheme was stopped and started again. A new scheme has been designed, as Sir Chris has highlighted. If there are any costs you could give to the loss of nurses when we saw the dip because of the bursary, that would be helpful. Could you write to us about that?

Lee McDonough: Just to be clear—it is a really important point to clarify—we saw a reduction in the number of applications but not an overall reduction in the number of acceptances. Last year we saw a 6% increase, which led to the biggest figure for the number of successful applicants in the last 10 years.

Q76 **Chair:** Were those nurses all domestic? Is that the domestic figure or does that include overseas?

Lee McDonough: That is into training. There are two different things. There was a significant drop-off in applicants, but if you look at the numbers of acceptances—the number of people actually going into an undergraduate training programme—there were more last year than at any point in the last 10 years.

Q77 **Chair:** Did you have any breakdown about background, such as socioeconomic or ethnic background, about the people who accepted, or could you write to us about it, if you don't have that to hand?

Lee McDonough: I don't have it to hand. I will have to check what is available on that.

Chair: If it is not available, one of the questions we might then ask is why, but could you check first? Sorry, Mr Mohindra. Back to you.

Q78 **Mr Mohindra:** It would probably be useful to get confirmation that the increase in acceptance did not mean a reduction in criteria. Obviously, there is a financial incentive for universities to accept undergrads. Could we get confirmation of that?

Lee McDonough: The other thing to clarify is that applications are way above acceptances. The 70% drop off of acceptances before the bursary was a significant reduction, but there used to be about two thirds of applicants who weren't accepted, so there was still plenty of headroom between applications and acceptance numbers.

Q79 **Mr Mohindra:** Obviously with doctors you commission courses directly. Do you think that is required for nurses, notwithstanding what you said about the high level of demand?

Lee McDonough: As Sir Chris has set out, the Government policy became to open up the market by using access to student loans rather than direct commissioning, as was the case previously. That is the Government policy and that is what we are working within at the moment.

Q80 **Mr Mohindra:** Sir Chris, with the new maintenance loan, how confident can you be that that is going to be a sustainable method of making sure that we continue to have a pipeline with nurses coming through the education system?

Sir Chris Wormald: It is early days, clearly. As Lee has set out, the only indications we have from this year's round are positive. To that extent, we are confident that changes we made appear to be having the desired effect. Quite clearly, we will have to monitor that extremely closely in the coming years, but the general policy of seeking to be much more targeted on specific problems, as well as providing general support, gives us a much more flexible policy package that is much easier to adapt going forward, if new issues in particular specialisms or geographical areas arise. As a piece of policy able to respond to events I think this is a much more sustainable position, but hand on heart, with just one year's initial data we can't be completely confident for the medium term.

Chair: I am glad you are not overplaying that, Sir Chris. You are right. It is only short term.

Q81 **Mr Mohindra:** Just on that, it would be interesting to see what demographic has changed, off the back of moving from the grants or bursary to a loan system. I would suggest that if you are of an older age, with family commitments, that may disincentivise you, off the back of the bursary, which is obviously not payable back. If we can get that information it would be useful.

Sir Chris Wormald: Yes, we will work—there is some information already set out in the NAO Report. Actually, figure 11 gives some of the macro numbers that you were looking for. As Lee McDonough said, we did see a particular drop-off in mature applicants as a response, and that was one of the reasons why there was a change of policy, because that is a potentially big source of nurses. I am sure we have further information on the demographics of all this, that we can send the Committee after the hearing.

Chair: Thank you. We will be very keen to look at that.

Q82 **Mr Mohindra:** My final question, if I may, to Dr Radford: obviously, once we have got students in place, can you just update the Committee on the progress you have made to reduce the drop-out rates of nursing students and increase the number who actually complete the three-year study?

Professor Mark Radford: HEE has been very cognisant that recruitment of students into the programmes is only part of the story. Actually, as you rightly pointed out, the attrition rates have varied across the different branches, for different reasons. We know that there are two specific challenges. One, often, for some students, is the financial challenges they face. Student nurses are very different from other types of student—particularly in terms of the length of the course, because of the placement requirements and also some of the up-front costs they have in relation to their placement experience. The second is both academic and placement support. As Lee and others have identified, some of the packages—particularly the financial support elements that are going in this September—will go some way towards being able to resolve some of the issues around course attrition. HEE is also leading a programme called RePAIR, which directly involves supporting individual universities and hospitals—some of those with some of the highest, as we would say, attrition rates from courses.

There are two elements to attrition. One is that students leave the course and never go back to training. Actually that is a smaller number. So we need to identify what those are and then ensure that those students go back. Also, some people intermit. Some people step out of their programme for a period of time and go back in. What we are trying to do through the RePAIR programme and the 50,000 is make sure that we can reduce the level of attrition from courses by around three or four percentage points, which would add a couple of thousand—2,000 or 3,000—additional nurses at the end of the programme.

Also, it is not just about those stepping off; it is about making sure that for run-throughs—those people who step off and take some time out and come back in—we reduce the time that they spend out of programme, so that they can continue. If we were to look at the core attrition—i.e. the run-through component of that—nursing attrition is there or thereabouts, in relation to other types of programme; but of course step-off is one of the areas where we absolutely need to focus. So we have got two: we have got a policy lever and a programme of activity both in trust to be able to target all branches, and specifically those that progress into work.

Q83 **Chair:** Do you analyse why people step off? Have you done a detailed analysis of why that is?

Professor Mark Radford: There was a published report on the Health Education England website called RePAIR, which I can share with you, Chair. We are currently revising that at the moment with a further piece of analysis and work.

Chair: The first thing is to know the problem and understand it, isn't it? Clearly you are doing that.

Q84 **Olivia Blake:** Some written evidence we received says that at one institution a third of their nursing students stepped off their courses to help out in covid. They subsequently had their placements end early—or never started; so they have actually missed out on hundreds of the hours they need to qualify. Why didn't the Department stagger this recruitment during the crisis, to avoid this? That is to Ruth May and Chris Wormald.

Ruth May: I welcomed all the 20,000-odd student nurses who came back to us. Their paid clinical placement was an important part of our covid response. I will hand over to Mark, who has been leading the student nurse work.

Professor Mark Radford: We set out to ensure two things. First, we ensured that all students could gain experience during covid, to ensure that they could aggregate their hours for completion, particularly for third-year and second-year students.

Under normal circumstances, we vary the start times of student placements. When we started this process in March, some students were already out on placement in their third year. Some go out in May, June and July. We already had a staggered programme in relation to the support of the paid placement options.

Managing large numbers of students was a huge logistical exercise, particularly as we asked for volunteers, so we had to assess each individual student and each university. About 14% were classed as "out of area", which means they study in one city but had gone home, because the course was paused by the university, which meant that we were arranging for placements elsewhere.

We have been working through with local trusts and universities to place as many students as we can, to aggregate the large number of hours. It is key that once students have those hours through the paid placement option, particularly if they are in their third year, they then need some assessment and support time before they can go on to the full NMC register as a fully registered and qualified nurse.

Other students who have been stepped out of programme or started a little bit later will have the continuity of the paid placements, particularly third year students, until they reach the number of hours required before the NMC curtail the emergency standards towards the end of September.

We are absolutely focusing on the students' completion of hours. There has been a staggered start time; there will be staggered finish times. Importantly, we will ensure that students who opted out come on to normal placements as well, so they can complete as close as possible to their normal graduation date.

Q85 **Olivia Blake:** Given that, how will you ensure there are enough safe and productive clinical placements for the next academic year? We are not out of the woods yet with covid-19.

Professor Mark Radford: No, absolutely not. We are working directly with the university sector, with deans and others. We are sequenced and we are operationally managing it on a weekly basis to understand which students have completed and are stepping on to the register, which students are being stepped out, meaning they have opted out, and which students need to go into paid or supernumerary placement.

We are also doing a centre check with each university to understand the number of hours each individual student has left to complete, so that they graduate on time. With 67 universities and 40,000-odd students, we are cognisant of doing that piece of work, which will conclude over the next week or two, so that we can have a clear plan to ensure that those students who can graduate can do so, those who continue on paid placement do so, and we reintroduce supernumerary placements in the autumn, particularly dealing with those students who might need to make up a few hours before.

We anticipate that the majority of third years will be able to graduate on time. We are just working through an assessment at the moment. But there will be a legacy cohort that will need to complete some additional hours beyond September for them to graduate this year.

Q86 **Olivia Blake:** That is a lot of extra work. A majority can be 51%. How many do you think will not finish their course on time and how does that affect your estimations for the next five years?

Professor Mark Radford: Large numbers of third year students were able to complete paid placements: around 82% of those who were able to volunteer had done so. The assessment check that we are doing at the moment suggests that potentially 20% of students will have a challenge in terms of completion of hours. For some, that will be as simple as three or four weeks. For some, it may take up to 12 weeks to complete their study.

Again, we are working with the university sector to map that our and ensure they get as many hours as they can during the summer and into the early autumn. For any student who needs to progress beyond the September date, we are currently working with the Department of Health and Social Care in relation to additional measures that we might need to support those students.

We also have the February '18 cohort, which was a group that started in February 2018 and will graduate in February 2021, and they will have some hours to make up as well during the autumn period. We are

ensuring that the placement opportunities are as evenly spread as possible between now and December, to ensure that we can deal with both groups.

Q87 **Olivia Blake:** I understand that it is getting increasingly difficult to get clinical placements at the moment. How will you prioritise these different cohorts of students?

Professor Mark Radford: The prioritisation is twofold: for our third-year students, who have to make up hours, we have a plan for in terms of paid placements. We have opt-out third-year student, who absolutely need to be identified in terms of the number of hours they need to make up—as I say, that could be three weeks or three months—and then sequence their placements during the summer and into September, for them to complete on time.

The next priority cohort are the January 2018 cohort, because they will qualify in January 2021 and possibly have 200 to 300 hours to make up during September through to December. So, they will be priorities.

In addition to that, two weeks ago, we launched expressions of interest from the NHS systems, including social care, for additional placement capacity. So, Health Education England is putting £10 million into additional placement capacity, starting this September, to ensure that we have enough placement capacity to support our students who have some delays, but also—importantly—for new students who wish to start their course, but of course new students starting in September will not go out on placement until January or February 2021. They can then spend their first semester in university.

We have got a condensed programme between now and December to deal with our students who have been delayed, but also we have tried to maximise, and I am awaiting the data at the moment in terms of the additional placement capacity the service will be offering over the next few months.

Q88 **Olivia Blake:** How is the Department currently working with the profession in the development of the education policy? Do you think that that is a strong enough link?

Lee McDonough: We have regular engagement with the whole range of stakeholders to take account of their views and input them in our policy development. We work particularly closely with Ruth as head of professions—the Chief Nurse—and also with the RCN and others, and with the Nursing and Midwifery Council as the regulator. We have very good relationships with them and work closely with them on a whole range of issues.

Q89 **Olivia Blake:** I think that was one of the things that was highlighted in our written evidence—that the link perhaps wasn't felt as strongly as the workforce would like. Do you think it could be improved further?

Lee McDonough: Is it through the RCN side that you are thinking about, or just the link right down to the individual frontline nurses?

Q90 **Olivia Blake:** It is more to do with the leaders in the sector.

Lee McDonough: Clearly, there is always more one can do to continue to engage, but I am very clear that we do engage on a regular basis with the leaders of the RCN. I have regular weekly meetings with the chief executive of the NMC and I probably speak to Ruth and to Mark in their professional capacities several times a week. So, I feel there is quite good connection and input into our overall decision making.

Q91 **Olivia Blake:** What do you think the impact is in terms of release from the workforce to teach at the moment, because I understand that this might be one of the issues and that it is becoming increasingly hard for nursing staff to get time off to teach? And what impact might that have on the quality of teaching, as well as the quantity?

Professor Mark Radford: One of the key aspects of the work that we are doing now in terms of additional placement capacity is directly to fund and support, and I will use an example—practice educators and support facilitators. One of the things is that we have had some changes in terms of the NMC scope in relation to how we support assessments against student requirements, but there is a range of things that need to go into a clinical setting to ensure that the student achieves the outcomes they require.

For some wards or departments, or working in somebody's home if you are a district nurse or in a mental health setting, additional educators are quite critical to the outcomes for students in support of the team delivering the care. So, we have a range of different options. Not only do they get assessed by local mentors, but we are adding in additional capacity to support students in their learning outcomes while they go through. We recognise that during covid it has been very difficult and challenging for many students, but during the next few months as well we are going to be putting in additional support to ensure that they can achieve that.

Q92 **Olivia Blake:** In terms of covid, how are you protecting the wellbeing of nursing students? Also, linked to that, do you think that fees could be looked at in terms of retention and what might encourage more students if they think they are not able to pay these off?

Professor Mark Radford: I will probably defer to my DHSC colleagues on the fees question as that is part of Government policy. In terms of the support for students, it is a really important question. We are currently doing a survey of our student nurses who have been on covid to ask some detailed questions on a range of issues: what they have experienced and what issues and challenges they have been exposed to, particularly in relation to issues such as moral hazard and mental health, and also in terms of their intentions and their courses. That is currently being concluded and we will use that to guide further intervention. However, we have not left it there.

We have actively engaged with students all the way through this process. We have held a range of webinars and engaged with student leaders, who

have given us consistent feedback all the way through the pandemic about issues and challenges from a policy perspective that we needed to change. So I have to commend some of our student nurse leaders who have been phenomenal during this process and have helped guide and shape policy. They have absolutely put front and centre the issue around support for students, whether that is pastoral or financial support, hence the package of finance to support paid placements. Also, importantly, as Prerana has talked about, all of the opportunities and support around mental health services are also and were always offered to students during their pandemic.

We are also engaging directly with the university sector, because, obviously, these students also have a pastoral responsibility back at their university. Again, they are very geared in terms of experience and support, whether that is in practice or in education, to understand the issues for an individual student. But they will be very varied and will not be immediate. We will expect issues such as they may have experienced during the pandemic around mental health and so on to emerge weeks, months, even years, later, so we must be sighted on the types of intervention and support for some of our students now that will need to be addressed when they are actually qualified and working in the workforce. We need to be really clear on that.

Q93 **Chair:** There are clearly a lot of challenges coming out of covid. Thanks to Ms Blake for highlighting those. Students are part of that supply chain for that elusive 50,000, or maybe not, depending on how well you do. I have one quick question on the nursing issue and then I will turn to you briefly, Sir Chris, on some money issues.

Black, Asian and minority ethnic staff, or people, are disproportionately hit by covid, and we know that there have been measures to protect people from the frontline. My concern is that this could lead to people having less support and progression because they have been taken away from interesting roles in order to protect their lives, which is a good thing, but there could be an unintended consequence—I would hope it is unintended—and they would lose the opportunity to progress in other ways. I am not sure which one of you is best placed to answer that one. I am looking at the list to see which hat you are wearing. Would that be you, Prerana, or Dr Radford?

Prerana Issar: It has been heartbreaking to see the disproportionate impact of covid on BAME communities, as well as BAME staff. Ever since covid started in this country, employers, who have responsibility for health and safety for their staff under the Health and Safety Act, have taken steps to protect staff.

Q94 **Chair:** Quite right. They are protecting staff, but it is the long-term impact on their career that I am asking about. How are you making sure there is no detrimental impact on their career progression?

Prerana Issar: We have helped employers to have a stratified risk assessment approach. A clinical reference group has created that stratified approach. All BAME staff have been asked to be risk assessed by

employers, and they are doing that right now. The feedback they are giving is that there is no automatic redeployment of people. There are a range of measures being taken to protect staff, which might include enhanced infection prevention and control measures, enhanced PPE, communication, and training for staff who may be between clinical areas.

It is a conversation that is difficult. We are seeing that, when it is done well, it is creating an environment of trust, rather than the other way around. But I have to say that we have to take this moment, which has, tragically, been opened up by covid and the Black Lives Matter movement, to ensure that we take a huge step forward in the equal and inclusive treatment of all of our staff—BAME staff and staff with other protected characteristics—from the—

Q95 **Chair:** How are you going to monitor that? The NHS may be one body, but it has got lots of parts. How will you ensure that there is good practice to ensure that no one is discriminated against in terms of career progression, even inadvertently, because they are being protected for health reasons? You have described some of the best practice that can take place, but I am sure it cannot all be good at the pace at which it has happened. Is there anything you can do from your position to prevent that or to keep an eye on it, to ensure it is monitored?

Prerana Issar: We have been taking action in four areas. Of course, there is the pioneering workplace race equality standard—the RES—that tracks data around whether career progression is happening at the same rate for all staff. As you say, we have seen some really good—

Q96 **Chair:** To be clear, presumably you break that down by sex, but do you break that down by different ethnic minority groups as well?

Prerana Issar: Absolutely, yes. The race equality standard has data around five or six key metrics around race, which include career progression. So we have data for differential—or not—rates of career progression for every trust and every employer across the NHS, which we track. Trusts and trust boards especially have a responsibility to ensure that that differential—a differential exists between white staff and BAME staff—is addressed. Each of them has access to the data and has a plan through the RES initiative.

Through the pandemic, every six weeks I have convened a national meeting of BAME staff, network leads and EDI leads across the NHS where we are asking what support staff networks and staff need to be able to have that support that staff need during covid. I have to say, there is a lot of variability across the NHS. In some ways we reflect society, but in other ways what we need to do at this moment is lead the country in terms of—

Q97 **Chair:** Okay. I am glad to hear it is on your radar. We would be interested to keep in touch with you about how well that is going. It sounds like a clear and good plan, but obviously the challenge is getting that to work in every trust.

Can I briefly turn to Sir Chris? When are you expecting to file your annual

accounts?

Sir Chris Wormald: I think—I will check the exact date with Mr Williams—we are aiming for after recess now. Actually, my National Audit Office colleagues will probably know the exact date, but I think we are headed for after the summer.

Q98 **Chair:** You say after the summer. I know the recess date came forward a week, so do you mean next week or do you mean September?

Sir Chris Wormald: No. I think we have to file them while Parliament is sitting.

Q99 **Chair:** Exactly—that is what I thought you had to do. That is fine. We will be crawling all over those in detail, and one thing I will want to crawl over with my colleagues is the long-term funding issue. Trusts have had large amounts of covid money, and we have seen this spent in interesting and different ways in different trusts, with a lot of temporary staff recruited, and planning for the potential next peak. A lot of that short-term money can take a while to spend, but there are still some underlying structural problems in the NHS that we have highlighted in a number of Reports. Can you say to us now that trusts will be protected on their base funding and that the covid money that has gone in will not in effect be an up-front payment for day-to-day spending in their normal budgets?

Sir Chris Wormald: I am not quite sure I understand the question.

Q100 **Chair:** Is the covid money going to be taken off the total? Can you be clear that this is definitely additional money?

Sir Chris Wormald: The Chancellor's pledge on this was extremely clear—

Chair: Perhaps you could repeat it for us: that would be good.

Sir Chris Wormald: We have a Long Term Plan that we made. I am not quite sure I understand your question, but there is no—

Q101 **Chair:** Let me put it this way: even among trusts, because there are differences, there can be disagreement about how covid money is spent. Some people may say it was not spent as well as by others. I am not making a value judgment on that. You can see how it would be spent differently. Some of that may be considered not as well spent as in other places. I wonder if there will be a day of reckoning for trusts when they will be evaluated on what they spent, which will be fair enough, but they may then lose out on any longer term settlement from the Government and the Department as a result of how they handled covid spending.

Sir Chris Wormald: There are no plans to do what you suggest.

Q102 **Chair:** Just to be clear: I think there is a lot of worry in the sector about what will happen post-covid when everyone no longer has the extra money.

Thank you all for your patience, as we have gone on a bit longer than we

expected. Thank you to our witnesses, Sir Chris Wormald; Ruth May, the chief nursing officer for England; Dr Mark Radford, the chief nurse for Health Education England, and it is refreshing to have some nurses in front of us; Lee McDonough, the director general for NHS and workforce; and Prerana Issa, the chief people officer for NHSE&I.