

Health Committee

Oral evidence: Nursing workforce, HC 353

Tuesday 28 November 2017

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[Watch the meeting](#)

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

Questions 178 -338

Witnesses

[I](#): Professor Ian Cumming OBE, Chief Executive, Health Education England.

[II](#): Professor Jane Cummings, Chief Nursing Officer and Executive Director, NHS England; and Ruth May, Executive Director of Nursing, NHS Improvement.

[III](#): Mr Philip Dunne, Minister of State for Health; Professor Jane Cummings, Chief Nursing Officer and Executive Director, NHS England; Professor Ian Cumming OBE, Chief Executive, Health Education England; and Ruth May, Executive Director of Nursing, NHS Improvement.

Written evidence from witnesses:

- [Health Education England, NHS Improvement, NHS England, Department of Health](#)

Examination of witness

Witness: Professor Ian Cumming.

Q178 **Chair:** Good afternoon. Thank you for coming to our final session, Professor Cumming. For those following from outside this room our inquiry into the nursing workforce, could you introduce yourself and your role?

Professor Ian Cumming: My name is Ian Cumming. I am the chief exec of Health Education England, which is the NHS body responsible for the education, training and development of the current and future workforce, and for workforce planning.

Chair: Thank you. Rosie Cooper is going to start the questioning today.

Q179 **Rosie Cooper:** Good afternoon, Ian. At the time of Mid Staffs and after Francis, staffing levels were a focus of great attention and ward staffing levels improved, but they seem to have worsened currently because of nurse availability and financial pressures within the NHS. Current evidence seems to suggest that workforce planning is now based on affordability rather than need. That, again, is based on insufficient data. I would like to ask you what the future projections for the nursing workforce are based on and whether you believe that is affordable with the pressures that we have.

Professor Ian Cumming: Part of the challenge we have with producing the nursing workforce is that we are dependent on decisions that were made four years earlier. People who are coming out of nursing education at the moment are as a result of commissions made back in 2013. Therefore, there has to be some form of projection in terms of an estimate over what people will need in the future. Historically, that estimate has been made on aggregating the number of nurses that NHS employers are predicting they are likely to need. Again, looking back over history, that has always underestimated the real demand.

But we also need to remember that there is another side to this coin. It is not just how many nurses are produced who may choose to work in the NHS; it is how good the NHS is at retaining those nurses once they have entered employment. We need to plan for the future workforce, but we then need to make sure that we retain those people within the workforce once we have got them.

As to your question specifically, instead of looking ahead five years, which was our traditional model, we are now starting to look ahead 10 years and at a variety of other factors—not just demand from the NHS for future nursing workforce but predictions around what we think may happen in terms of growth in the economy, growth around GDP, and what may happen as to the percentage that is being invested in our national health service, to look at whether that gives us a different line against which we can plan future supply.



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Q180 Rosie Cooper: Obviously, you believe this new way of doing it is better. Ten years would sound a lot better to me, but we have known each other a long time. Historically, it is stop-start stop-start, and we have never got workforce planning right at all. If you are going to do it and it is based on data forecasting over 10 years, where do you think the gaps are in that data about the nursing workforce and what can we do to address it now?

Professor Ian Cumming: One area where we would like to reinstate data collection is around what the actual number of vacancies for nurses is at the moment. We have data collections that we undertake and we have data collections that colleagues in NHSI undertake, but the formal collection of data relating to vacant posts in the NHS was stopped a number of years ago and we are keen to reinstate that so that we have a formal data collection that allows us to know what the actual position is now for vacancies so that we can better plan the future.

Q181 Rosie Cooper: You have just said you are keen to do it. Why are we not doing it?

Professor Ian Cumming: A formal data collection would require a process to be put in place to do that, to make it official statistics, and we will be seeking that as a recommendation in our workforce strategy that will be coming out. We do require others to make the decision to allow that to happen. We are collecting it between the arm's length bodies, but we would like to put it on a more formal footing.

Q182 Rosie Cooper: As it is so basic to your future planning, can you give us any assurance of when you think that will happen?

Professor Ian Cumming: NHS Improvement is doing a data collection now, but that is not the robust ONS-level data that we hope will be produced. I cannot give you a specific answer to that because that would be out of our hands, but we would certainly hope that would be very soon.

Q183 Rosie Cooper: In whose hands is that?

Professor Ian Cumming: It is the Department of Health.

Q184 Dr Caroline Johnson: Professor Cumming, when you said you were looking 10 years ahead, that is great news, but you said you were going to look at planning how many nurses you need—I may have misheard you—using figures such as GDP and the percentage of GDP that may be spent on the NHS. Does that not tell you how many nurses you potentially could have rather than how many you need, and is it not more about demographics, morbidity patterns and immigration, which give you an idea of what the demands on the service are going to be, that are going to be more predictive than how much money you might have?

Professor Ian Cumming: Absolutely. We are trying to factor in all the variables to determine what we need and, instead of just having a line that is dependent on NHS trusts predominantly telling us what they think they would employ, to add in a number of those other factors that you



are talking about. Clearly, the population is ageing and growing; the number of people with long-term conditions is increasing; the participation rate—how many hours people work per week—is actually declining. We need to factor all those in to the modelling around how many nurses we need to train for the future rather than simply asking NHS trusts what their view is on the predicted demand level for that trust.

Q185 Chair: One issue highlighted in the NAO report was that we may be doing more about planning for financial viability than for patient safety. How are you going to redress that balance and speak truth to power about what we need for patient safety as opposed to making ends meet?

Professor Ian Cumming: That is one of the problems with the model that we have used historically where we have asked employers to tell us what they think their demand need is for the future. They have always built the affordability—the likely budgetary factors—into that, and that has led to the underproduction of nurses historically. But we do need to bear in mind that we have increased the number of nursing commissions consecutively in each of the last five years and at the moment we are dealing with decisions that were made in 2009, 2010 and 2011—that sort of period—where, absolutely, financial consequences were fed in as probably too great a factor.

Q186 Dr Williams: The NHS of the near future, I hope, is likely to have much more of its workforce working outside hospitals and maybe not even working for acute trusts. Do the plans take that into consideration?

Professor Ian Cumming: Yes. Where we are able to, we factor in non-NHS employers. Some of that has to be done as a proxy because we do not have a data collection, for example, from every independent sector employer of nurses, but we certainly do factor in demand for social care and for nurses working in community trusts, mental health and the primary care environment.

Q187 Dr Williams: Do you mean “factor in” as in are we predicting a doubling of people working outside hospitals within the next five years?

Professor Ian Cumming: It is not doubling but we are certainly predicting a growth in the amount of care that is delivered outside the hospital environment, yes.

Q188 Chair: Going back to a point you started to touch on, to reflect back, Sir Robert Francis told us there were huge numbers of staff working in, frankly, unacceptable and unsafe conditions. How are you going to factor that kind of issue into your recommendations?

Professor Ian Cumming: It is our job to make sure that we produce the workforce that the NHS, and indeed the country, needs for the future and to make sure that we are using the levers we have with universities and other organisations to help produce that workforce. It is not our role directly to determine what the required staffing levels are for



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organisations. We turn to others for advice. We turn to the chief nursing officer and chief nurse for NHS Improvement in terms of advice and guidance on what is trying to be achieved there.

We do need to remember, though, that the last five years have seen an increase in the number of nurses in employment in the NHS, so it has not gone down. Over the last five years, the number of nurses in substantive employment in the NHS has gone up by about 14,000, and the ratio of nurses to occupied beds in the NHS has also gone up from about 1.84 to just over 2. We are going in the right direction. What we are not doing is moving as quickly as people want or need to in order to address many of the quality issues that came out in Robert Francis's report into Mid Staffs, for example.

Q189 **Chair:** That figure is going to go up if you cut the number of overall beds in the NHS.

Professor Ian Cumming: No. That is with, broadly speaking, the same number of beds over that time period. The actual number of substantively employed registered nurses in the NHS has gone up by 14,000 in the last five years.

Q190 **Chair:** In terms of our international comparisons with the number of nurses employed, is that something you look at as well?

Professor Ian Cumming: It is. It is one of the figures that we use and we are, broadly speaking, middle of the pack in terms of most European countries if you add into those figures nurses working in the independent sector. I stress that I am not saying that we do not have a shortage of nurses at the moment, because we absolutely do have a shortage of nurses in substantive employment in the NHS. That is because, at the same time as the number of nurses in employment has gone up, our demand for nurses has also gone up, so we have a large number of vacancies for nurses, which is somewhere in the region of 35,000 vacant posts for nurses at the minute in the NHS.

Chair: Thank you. Paul wanted to come in.

Q191 **Dr Williams:** Robert Francis also told us that, as an inadvertent consequence of his report and determining safer staffing levels in acute trusts, the number of nurses working in acute trusts has increased but the number of nurses perhaps working in a mental health and community setting has decreased. Is that something that you recognise?

Professor Ian Cumming: We absolutely recognise that as a result of, I suppose, what we call the Mid Staffs effect—that is both the CQC work around Mid Staffs and Robert Francis's report into Mid Staffs—the demand for nurses in the acute sector in the NHS went up by about 35,000 whole-time equivalents over a three-year period, which is a phenomenal demand if you bear in mind that we see somewhere in the region of 22,000 nurses a year coming out of training. There was an absolutely enormous demand over that period as a result of people



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focusing on the quality of care being delivered and what is the right number of registered nurses needed to care for patients. Some of that demand in the acute sector has undoubtedly put pressure on nursing in other sectors—social care in particular but also some community nursing jobs. People have been attracted into roles in hospitals to help meet some of that demand.

Chair: I have quick follow-up questions from Caroline and Luciana.

Q192 **Dr Caroline Johnson:** I have two questions. To be clear, you said there are 14,000 more substantive nurses in the NHS. Are these nurses in clinical nursing roles or are some of them in management roles, and do you count them differently? Also, are they whole-time equivalent nurses—each of those—or is there a smaller number for whole-time equivalent increase in nurses?

Professor Ian Cumming: No. It is absolutely whole-time equivalent. In terms of some of them being managerial people, they will be coded as nurses on the NHS electronic staff records, so the vast majority of them will be clinical nurses. They will not be people who are coded as administration or management.

Q193 **Dr Caroline Johnson:** But they could be in management, practice development, advanced practice or specialist roles.

Professor Ian Cumming: Certainly they will be in specialist roles and advanced practice. I think it is unlikely that many of them will be in pure managerial roles.

Q194 **Luciana Berger:** Of the 5,434 fewer nurses now working in mental health since 2010, how many of those are working to plug the gaps, as you put it, and to address the issue in the acute sector?

Professor Ian Cumming: I do not know. I cannot answer that question. I would not have that data because we do not track every individual nurse as they move through different employment.

Q195 **Luciana Berger:** Would they have the training as a mental health nurse to be able to be transferred into the acute sector?

Professor Ian Cumming: Certainly, if people wish to transfer between different branches of nursing, then there will be different training requirements for individuals to be able to make that transfer.

Q196 **Chair:** Before we move on to retention, one issue we also heard was the different ways of recording staff vacancies in the community and nurses working in community settings, such as nursing homes and hospitals. In the workforce recommendations that you are making about the workforce strategy, will you be coming forward with very clear recommendations about how we can do this effectively across all sectors, including those—

Professor Ian Cumming: Certainly across the NHS we will. It is very hard to be able to capture the level of data across the very large number



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of independent employers that we have in social care, for example, but we will be talking to groupings of employers. I am working with colleagues in Skills for Care around trying to identify what the shortfall is in the social care setting.

Chair: Paul wants a quick follow-up before we move on to Maggie.

Q197 **Dr Williams:** How much is availability of training placements, particularly in mental health and primary care, a limiting factor in workforce planning?

Professor Ian Cumming: At the moment it is not huge and, generally speaking, we manage to place all the student nurses whom we are looking to train. With the recent announcement of the 25% growth in undergraduate nursing student places and funding for those places, we are starting to talk to people about what challenges they are facing; but at the same time the Nursing and Midwifery Council is consulting on a change to its regulations, which, for example, would allow nurses to spend a greater percentage of their time in a simulation environment, which then frees up more opportunity in the overall training. We also have a number of environments in which we do not train at the moment that could be quite rich training environments. By bringing groupings of employers together, looking at what more training can be provided in the community, we think that we have adequate training placements across the sector.

Chair: We are going to come on to that in more detail as we have a whole section on it. Just looking now at retention, a key issue that was raised with us was continuing professional development, and Maggie is going to lead on that.

Q198 **Maggie Throup:** Before I start on that specifically, can I bring you back to an answer you gave a few minutes ago when you talked about nurses in the acute sector being able to transfer to different sectors, whether it is social care or mental health? We heard at the focus group last week that if nurses want to do that—it is one way they will stay in the profession, to go into different areas— they have to take a few pay grade drops. What can you do about that?

Professor Ian Cumming: That is down to individual employers and what they choose to do, but to work as a registered professional in a particular area requires you to have the professional qualifications to be able to operate in that area. If people are moving sectors, clearly they need to make sure, to be able to operate as a registered professional in that area, that they have the required training and education. If it means that to move areas they need to take a backwards step, some people are choosing to do that.

Q199 **Maggie Throup:** The message coming out was that we are losing nurses because of that, because they cannot afford to take a backwards step. They were quite concerned about that. It was one way you could retain



more nurses. Looking at CPD, what is your view on the reductions to nurses' CPD funding that has happened over the last few years?

Professor Ian Cumming: This is a very complex area. CPD means different things to different people. There is CPD that is associated with what a professional needs to do to retain their status on the register on an ongoing basis, which is usually a minimum number of hours of revalidation update and professional training to maintain your place on the register.

There is also workforce transformation money, which is money that is invested in the NHS workforce to give them a new or different set of skills, or indeed in some cases to refresh their set of skills. Within HEE, we have a workforce transformation budget—currently at about the £80 million mark—that we allocate across the NHS on an annual basis. That is less than half of what it was in 2013-14. It has come down from about £190 million to about £84 million. On top of that, we spend £300 million a year on what is called salary support. Coming back to your earlier point, that is paying salaries for people while they retrain in a different area or train in a particular area. For example, at the moment we are training nurses to become nurse endoscopists. While they are in training, we are paying those individuals' salaries because it is a priority. We want more nurse endoscopists; so, we pay the salary to allow people to continue to earn while they are going through that training to meet a need that we have in the NHS.

The reason that the budget has gone down is as a result of conscious decisions that we made. When we came into being as Health Education England, we were being told very clearly indeed that the priority was to grow the number of undergraduate nurses that we were training. We started to invest quite significantly in growing undergraduate nursing training commissions, which were at 17,000 in 2012 and grew to 20,000 in 2016. Some of the money that we had historically spent on the current workforce through workforce transformation we diverted into spending on the undergraduate workforce because we were working within a finite budget. That was a deliberate and conscious decision because we believed that the top priority was to train more nurses at that time.

Now we are looking at rebalancing, because undergraduate nursing funding is picked up through the Student Loans Company, and we are now looking at how we can prioritise more of our fixed resource into targeting the current workforce, because we believe that giving people access to education and training opportunities as well as helping produce the workforce we need is also something that helps motivate them, helps morale and helps keep people in jobs.

Q200 Maggie Throup: From your answer, I get the feeling that perhaps you do not feel that the trained nurses are getting the CPD that they really need.



Professor Ian Cumming: Certainly there is a much greater demand for CPD and for workforce transformation than we are able to fund out of our budget at the moment, but it is a joint responsibility between individual employers, HEE and in many cases between the individuals in terms of what they want to do as opposed to what we need them to do.

The other thing we have definitely done over the last couple of years is to prioritise the workforce transformation spend against those areas of particular priority. I mentioned endoscopy training. Training in ultrasonography would be another example where we are training midwives and other healthcare professionals in ultrasonography skills. Instead of just giving the money out and giving much more freedom over how it is used, we have tried to specifically target against areas of shortages and areas that fit in with the five year forward view priorities.

Q201 **Maggie Throup:** Are you comfortable that nurses are getting the CPD that they need?

Professor Ian Cumming: I would love to be spending more money on workforce transformation and CPD than we are doing at the moment, and it is our intention to use a greater percentage of our budget in that way over future years.

Q202 **Maggie Throup:** Once again, last week at the focus group a message that came out was that nurses were very concerned about the lack of CPD that they were able to access and it was causing problems with retention. That was probably more of a concern to them than their actual pay. They see that as being very important in their role. Do you think that the increased investment that you have alluded to will be there and can be funnelled in for these nurses?

Professor Ian Cumming: It is a combination. If you look at retention—how we keep the highly skilled, highly trained staff that we have at the moment—we have seen a deterioration over the last five years. If I go back to 2012, we used to lose on an annual basis for reasons other than retirement 7.1% of our nursing workforce. The latest figure we have for last year, 2017, is 8.7%. We are losing an extra 1.6% of our workforce on an annual basis than we used to.

That does not sound like a big figure, but it is 5,000 more nurses who left in 2017 than in 2012. If you look at the aggregate over the 2012 to 2017 period, if we had kept the 2012 retention figure right the way through, we would have 16,000 more nurses now than we do at the moment, which is about 50% of all the vacancies that we have in the NHS. These numbers are very large.

To answer your question specifically—to a certain extent this is anecdotal, although we are looking at providing some detail behind it—we run return to practice programmes for nurses in the NHS. Over the last four years, about 4,000 people have either started a programme or completed a programme and finished; and we have spoken to a number of those



people about their reasons for leaving in the first place. I do accept that we are talking to a cohort who are choosing to come back, so we may get a different answer. But in talking to that cohort of 4,000, the No. 1 answer that we have had back as to why they left was lack of flexibility in employment to fit in with childcare or whatever the circumstances are, such as, "I can't work Tuesday nights and my employer wasn't able to give me shifts that worked around Tuesday nights." That was the No.1 reason. Other reasons that came out included ongoing education and training opportunities, pay and pressure of work, but the No. 1 answer wasn't any of those—it was flexibility.

- Q203 Luciana Berger:** You talked about shortages and that being the reason to focus on training nurses to start off with, but in 2016-17—so last year—all specialist post-registration training programmes ended the year being under-recruited. That was training programmes for district nurses, specialist community public health nurses and also for health visiting training as well. It was a 22% under-recruitment figure for that level. My question is around investment for continuing professional development. Obviously, you need to sustain investment in this area to ensure that we have that pipeline of specialist nurses as well. How can you ensure that these cuts to continuing development, to that workforce development fund, will ensure we are going to have those very specialist nurses that our country needs?

Professor Ian Cumming: They are funded out of a separate budget. The specialist nursing posts in the community and elsewhere do not come out of the CPD budget. That is a separate allocation of resource, and the number of commissions in those areas have not been cut. There are some difficult issues, and district nurses is a particularly tricky one. If you look at the issue of district nurses on its own, the number of district nurses we have in this country has gone down. If you look at community nursing, the impact is nowhere near as significant.

As to health visiting, we had some specific parts of the country where locally they made a deliberate decision to not train as many health visitors as they had done previously because the demand for health visitors in employment was not there anymore and the feeling was that if we trained them we would end up with trained health visitors who would not be able to get roles.

Chair: We are going to come on now to the supply of UK nurses. Diana is going to lead on this section.

- Q204 Diana Johnson:** This is about the changes that were designed to free up the number of places that could be allocated for nursing. What are your projections about how quickly the numbers are going to increase?

Professor Ian Cumming: We are looking at how we allocate the training placement funding for the just over 5,000 additional nursing training places for which we have now been given the resource. Clearly, there needs to be a partnership between us funding those training



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placements, the universities recruiting the people on to those courses and the NHS working with them to identify where those people are going to be placed. It is our intention to have as many of those as possible operating from next year; that is with people who will be starting from the next intake into nursing.

Q205 **Diana Johnson:** So that I understand, that is 5,000 additional places you are saying. That is what you are projecting.

Professor Ian Cumming: If you want it specifically, 5,170 additional training places have been funded for clinical placements for undergraduate nurses.

Q206 **Diana Johnson:** How does that fit with the 25% increase?

Professor Ian Cumming: That is the 25%.

Q207 **Diana Johnson:** So 5,000 additional places is the 25%.

Professor Ian Cumming: Yes.

Q208 **Diana Johnson:** We had this focus group last week with nurses, and one issue that came out was that nurses are already working to capacity on the wards or in whatever role they have. What is your feeling about how easy it is going to be to find additional places? I know in an answer to Paul you talked about there being some places that do not currently provide placements that you might be able to use. Could you say a little more about that? Also, you mentioned simulation environments. Could you say a little more about how you think you are going to expand the volume of placements?

Professor Ian Cumming: Yes. There are a variety of things that need to happen. First, the money that we give to organisations for clinical placements needs to find its way to the areas in which people are being trained. We need to make sure, if we are placing nurses on a ward, for example, that the money we are giving that organisation gets to the ward where they are doing the training and it does not get used elsewhere within the organisation. That is something that we hear quite commonly. The organisation is taking placements but the people delivering the training are not seeing the level of resource. With regard to simulation—

Q209 **Diana Johnson:** Sorry, how are you going to do that? How are you going to make sure that it gets to the frontline?

Professor Ian Cumming: That is part of our work with individual organisations with whom we spend very large amounts of money on an annual basis. We have something called an LDA—a learning and development agreement—with every organisation, and it is tracking that to make sure that the wards and the departments are getting the funding through that LDA with the providers. If we are not getting the required input into education and training, then we will have to move those placements elsewhere because we would have concerns about the



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quality. It is about how we make sure that what is being purchased for education and training is being delivered.

Of course, if a hospital is putting an extra 0.5 whole-time equivalent on to a ward to deliver education and training, that is fine because we can be clear that that money is being used to fund that post, but it is making sure that it doesn't just disappear and doesn't get used for education training. The same applies with doctors, allied health professionals and other professional groups.

With regard to other opportunities for placements, we are trying to create an NHS where care is delivered close to where people live, with an in-reach into hospitals where necessary, yet we still train too much in hospitals with a bit of outreach into the community. One thing that we want to do is to look at how much more training capacity we have in the community, including in areas such as nursing homes, for example. We do have student nurses on placements in nursing homes at the moment, but we believe there is a lot more potential. We had a big nursing associate conference last week and I was really surprised and pleased, if I am honest, by the trainee nursing associates who were talking about how they were not looking forward to their placements in nursing homes—these are people who perhaps were working in hospitals and always had done—but how rewarding they found it and how much they learned from those placements. We need to take that learning and apply it to the registered nurse workforce that we are training as well.

With regard to simulation, we do have a lot of simulation used for postgraduate training at the moment, particularly of doctors. We have some very good simulation facilities in a number of our universities—some absolutely fantastic ones—and, as the NMC considers whether or not to change its regulations, a greater percentage of training can be delivered using that very high-technology simulation of training people in a safe environment first of all before putting them out to practise the skills they have learned elsewhere.

Q210 Diana Johnson: Can I ask one question about the trainers—the people who are going to provide the education? You have talked about moving it perhaps more into the social care setting and nursing homes. How reassured are you that you have the people with the level of ability to deliver that training in these new settings? What needs to happen to allow that to be the case?

Professor Ian Cumming: We would undoubtedly need to invest to ensure that that was happening and we would need to quality-assure the process by which we are using new placements. It is not something as to which you can simply say, "Please take a student for us." We would need to put support in for the people who are delivering the training, because for many of those people this would be new to them. Going back to your earlier point, we would also need to make sure that we are not adding more pressure and stress on to somebody who is already working in a



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very pressured and stressed environment without giving them additional resource to be able to do that.

- Q211 **Chair:** Returning to the issue of the change to nursing bursaries, we have heard that this might have different impacts on different groups of applicants, the greater effect being on the applications from mature students. Could you comment on that and what you are going to do to address that, because the attrition rates are lower traditionally for mature students?

Professor Ian Cumming: We would agree with that. Although we do not have the robust data yet, it certainly seems that the average age of the nursing students entering university this year is significantly lower than it has been in previous years. That is undoubtedly because a number of the mature entrant students have not chosen to apply to do a degree that is funded through the student loan route. We need to watch that; we need to see what happens; but part of the solution we are pursuing to this is that we want to keep the richness that we have within the registered nursing workforce. Therefore, by offering routes to get to be a registered nurse through the nursing associate qualification, for example—the most frequently occurring age group, the statisticians will tell me, within the nursing associate workforce is 25 to 34—we are picking up more mature entrants into that group who will do a two-year healthcare support worker to nursing associate qualification, and then, subject to agreeing the standards with the Nursing and Midwifery Council, they will go from nursing associate to registered nurse if they wish while working over somewhere between an 18-month to two-year period.

- Q212 **Chair:** It takes four years to take the apprenticeship route into nursing. It is using a workforce that you already have of healthcare assistants. You are losing the new entrants in through a faster route—the three-year degree route into nursing. Does that concern you?

Professor Ian Cumming: We think it is a strength because people are working while they are learning. The nursing associates are spending on average a day a week at university undertaking their foundation degree. They are spending four days a week caring for patients in the NHS, and we are taking people who in many cases would not have had the minimum entry requirements to access a registered nursing degree. So, it fits in with the widening participation strategy that we have as well.

- Q213 **Chair:** It adds in an extra route, but you are losing a route that was the core supply of nursing graduates, which was through the three-year route. Does that concern you?

Professor Ian Cumming: As long as we have a route that will be larger—it will potentially take a greater number of people through the nursing associate route—no, it does not. We would not want to see people who are older than 18 being put off from entering nursing, because there is a real richness that people who have learned experience—life experience—can bring into the profession as well as the



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people who see this as their vocation at 18 and that is what they want to do.

Q214 **Chair:** We have heard concerns that there are certain branches of nursing that are particularly impacted, such as learning disability nursing. What are you going to do to address that?

Professor Ian Cumming: Learning disability nursing is one area where we have seen a real impact as a result of changes this year. It is also an area in which we have a higher number of vacancies across the current nursing workforce. Currently, the vacancy rate in LD nursing is just under 15%, which is higher than we are seeing in most other branches.

Traditionally, LD nursing has been people entering who have been more mature, typically. We want to make sure that there is a nursing associate route through into LD nursing because we think that will be a popular route. As part of the expansion of nursing associates, we are looking at putting that in place. We are also working with colleagues in NHS England and NHS Improvement on a group looking at what is the future role of an LD nurse. We have closed down a number of large institutions in which people with LD used to be cared for and are very much trying to integrate people into the community and into society, so the role of the LD nurse is changing alongside that and we need to make sure that we are training people for the role of the future and not the role of the past. It is a relatively small workforce but a big piece of work.

Q215 **Chair:** You have identified learning disability nursing. What about other branches that you have identified where there are going to be significant shifts and shortages?

Professor Ian Cumming: The other main branch is mental health nursing where, typically, again we would see an older entrant coming through and, again, making sure that we have the nursing associate route. The other feedback that we had last week was how much people who had never worked in mental health were enjoying their mental health placements in the nursing associate trainee workforce. Again, we will make sure we have the nursing associate route in place there.

Q216 **Chair:** With the accelerated courses, the Nurse First programme, are you planning to offer any extra incentives for people to go into shortage specialties through that route?

Professor Ian Cumming: That is a programme that NHS England is leading on at the moment. The numbers are relatively small, but we want to evaluate that and ascertain the benefit of it; but, certainly, mental health and LD are areas that we would wish to prioritise in that sort of initiative.

Chair: Thank you. Now on to Andrew.

Q217 **Andrew Selous:** I want to ask you about attrition rates of university nursing degree courses. We understand from information that we were



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given by the Royal College of Nursing that you commissioned 18,000 places between 2013 and 2016, and that commissioning produced 11,900 nurses. We have further learned from the RCN that the average UK attrition rate is just over 25%, but that varies between a low of 9% and a high of 44.5%. That is a huge variation. What are you doing to reduce both attrition rates and, in particular, that variability between different institutions?

Professor Ian Cumming: The attrition rate has come down hugely over the last five years. It is one area on which the universities themselves have been working very hard. It is an area that we have been focusing on with them. The attrition rate has also come down as the academic requirements for entry have gone up, because some people perhaps found the academic content of courses quite challenging. Therefore, as the minimum standard for entry into courses has gone up, so attrition has come down. Variation between courses—

Q218 **Andrew Selous:** Can I stop you there? It is great that it has improved, but 25.1% is very high still, is it not? You cannot be satisfied with that, can you? Surely there are things we can do to support trainees as they go through that training. The fact it has improved is great, but that still seems a lot of nurses that we are losing—people who wanted to be a nurse who did not manage to achieve that.

Professor Ian Cumming: It is high, but we need to understand the reasons. We will gladly look at those figures and come back to you on that.

Q219 **Andrew Selous:** I know they are RCN figures, but I imagine they are of key interest to you.

Professor Ian Cumming: We look at attrition rates certainly from those student places that HEE has funded. There is variation between universities. Those universities that have done much more about widening participation have a higher attrition rate than those universities that have not done that same level of work. We would not want to discourage people from looking at the widening participation entry routes to nursing even if they have a higher attrition rate, because we think it broadens the range of people whom we are bringing into the nursing family as a whole. Certainly, we need to get that level down to the lowest we possibly can. We need to look at what is being measured, because some people do not finish a nursing degree in three years; it takes them four or five years. Is that attrition or simply a delayed completion of the programme? I would like to understand those figures, and perhaps I will come back to you in writing with some specific commentary on it.

Q220 **Andrew Selous:** This is the second week that it has come up in the Committee. We urgently need these nurses and you are spending money training them, from which you are not getting a result and the NHS and patients are not benefiting. Perhaps you could write to the Committee with your plan of action in that area.



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Professor Ian Cumming: Yes, and setting out what we have already done, because there has been a huge amount of work undertaken on attrition.

Q221 **Andrew Selous:** With respect, your answer is slightly complacent, it seems to me, because I think the figure is still quite high given the shortages that we have heard of.

Professor Ian Cumming: Okay, let me come back to you in writing.

Q222 **Dr Cameron:** Given the issues we have heard about recruitment, nurses leaving, and Brexit and beyond, do you believe there should be a co-ordinated approach to international recruitment, and, if so, who do you think should lead that?

Professor Ian Cumming: There should be and we are doing it. One challenge that we have had historically, I think, is that individual NHS employers have sought to plug some of the gaps that they have at the moment through initiatives to recruit overseas. Some of those have been successful; some have not. We have agreed that we are currently aiming to bring somewhere in the region of 5,500 nurses into the country internationally on an ethically-based earn, learn and return programme. We have started by piloting this with India. Registered nurses from India would meet the requirements of the Nursing and Midwifery Council. They would come and work in this country in placements that we are facilitating, and while they were here they would gain postgraduate experience in a particular area, be it intensive care, theatre, emergency medicine or whatever it may be, while working for us. Then at the end of their period of time here they would return to India, return back to the employer with whom we have partnered, and take that skillset back into the country from which they have come.

The first pilot cohorts are here, in Harrogate at the moment. We are aiming to have 500 here by the end of March this year, building towards the indicative figure that we have at the moment, which is 5,500. We believe that doing it that way is more ethically robust in that we are not denuding a country of their valued resource but allowing people to come here for a fixed period of time, yes, to help us with a staffing shortage that we have, but also to learn, to earn money and to take that back into their own country. We believe that is the way forward. We have an initiative with India, as I have already mentioned, at the moment, but we are also looking at establishing a similar initiative with the Philippines.

Q223 **Dr Cameron:** You say that these initiatives are ethically based. Is that in conjunction with the Governments of the other countries in agreement?

Professor Ian Cumming: Yes.

Q224 **Maggie Throup:** Last week at one of our focus groups we met a group of aspiring trainee nursing associates. One problem that they highlighted was the fact that they are not supernumerary. They found that, when they were doing their training on the unit from which they originated,



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they were not getting the opportunity to do the training that they should and were expected to carry out their existing work. Are you assured that we have the right system in place for these nursing associates and that they will get the training necessary?

Professor Ian Cumming: It is a pilot, and part of the reason why we started the first intake of a thousand was to exactly test out this sort of model. Can we train people, can they gain the competencies they need, can they get the training they need while working, or do we need to designate some ring-fenced time that is training time or whatever? We are hearing different things from different parts of the country already in the pilot. We have 2,000 trainee nursing associates now out and about around the country. We also have different models in terms of whether people go to the university for a block of time and come back, or they go for a day a week and come back.

I think the answer to that is that we need flexibility because, if you are in a rural part of the country, being expected to travel an awful long way every Friday, for example, is harder than if we say every fourth week or every fifth week you go off for a week. We are properly evaluating every aspect of the nursing associate training programme, and issues such as you have just described will be taken up on that evaluation. If there are concerns that people are not meeting the competencies or need some additional training, then we will flex the training to allow for that.

Q225 **Diana Johnson:** I want to ask you about the apprenticeship levy and the current problems with it. What is your view of that and what is your plan of action to deal with those problems?

Professor Ian Cumming: There are a number of programmes. This takes us back to the conversation we had earlier about CPD and workforce transformation money, because in many areas accessing the apprentice levy is a way of gaining that ongoing education and training for the workforce. To be able to access the levy, we need to have the standards and the programmes approved, and we need individual employers to then be accessing the levy vouchers from the funding that they have effectively had taken from their budget. That is different. That is not how we have operated in the NHS historically. In the NHS historically, we have had organisations such as my own who have said, "We are going to do this on a big scale across the country, so here is the money," or, "We have commissioned these places to allow it to happen".

We are now trying to engage with a large number of employers, reminding each of them that we can help put the structure around it, but the actual funding has to be accessed from them out of their own levy. One area on which we would like more flexibility in organisations such as the NHS is to be able to have a single organisation co-ordinating that on behalf of the whole sector. We have said that, at the end of the first year of operation of the levy, with NHS Employers, we are going to undertake a review of how it has worked, what is good and what has gone less well, with a view to hopefully making some recommendations on how we could



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do it differently. Certainly, if we could co-ordinate, for example, accessing the apprenticeship levy for nursing associates, as we seek to train 5,000 next year, trying to do that once for the NHS would be much easier than trying to do that through every individual employer.

Q226 **Diana Johnson:** On that point, is it your understanding that that could be done by changes in regulation?

Professor Ian Cumming: Yes.

Q227 **Diana Johnson:** It would not need any primary legislation to do that.

Professor Ian Cumming: I am not an expert in that area, but my understanding is that it would not require primary legislation.

Diana Johnson: It could be amended.

Chair: Do any other members of the Committee have follow-up points? No. Thank you very much for coming today, Professor Cumming.

Examination of witnesses

Witnesses: Professor Jane Cummings and Ruth May.

Q228 **Chair:** Good afternoon. Thank you both for coming this afternoon. For those following outside this room, could you both introduce yourselves and your roles, starting with you, Professor Cummings?

Professor Jane Cummings: Hello. My name is Jane Cummings. I am the chief nursing officer for England and I am an executive director at NHS England.

Ruth May: My name is Ruth May. I am the director of nursing at NHS Improvement, deputy as well to Jane, and the national director for infection prevention and control.

Q229 **Chair:** Thank you. The current shortage of nursing staff has been described to us as a crisis with a clear potential to impact on patient safety. Do you recognise that description, perhaps starting with you, Jane Cummings?

Professor Jane Cummings: We recognise that the NHS is under a lot of pressure and that, as you have heard from Ian, there are a considerable number of vacancies. It is fair to say that there has been such a huge attention to nurse staffing levels—particularly since 2012—that we now have a lot more funded people, funded posts, and, as you have heard, it is quite difficult for the NHS to catch up in terms of those recruitments.

At the moment, as to quality and safety, we do not have evidence that there is a significant impact. We do know, however, that there are a lot of staff who are working really above and beyond what you would expect them to do on a day-to-day basis in order to make sure that that happens. If you look at things like patient survey results—for example, the patient Safety Thermometer—and some of the incidents that are



reported, yes, there will always be pockets of quality issues and poor care, but, overall, we have seen a continued reduction in the number of falls, number of pressure ulcers, and so on, which would be an indicator through things like the Safety Thermometer that things were getting worse.

Q230 Chair: If you look, for example, at something like the MBRRACE study that was published yesterday, they make a very specific comment on the impact of the workforce on patient safety. That is just one study that has been published this week.

Professor Jane Cummings: We know that there is a link and some evidence that having the right number of registered nurses has an impact on outcomes. We know that it has an impact on mortality, morbidity, particularly in the work that has been done on acute medical and surgical wards. Fundamentally, you know that having the right number of staff is going to have a better impact on staff experience, patient experience and patient outcomes. The point I am making is that some of the evidence we have has not shown that at the moment other than in pockets. The work of the CQC and the work that NHS Improvement are leading around improvement and continuing to improve quality is there. What I am not saying, though, is that we should be in any way other than concerned about the ongoing gap that we have between the number of nurses that we think we need and the number that we have in post at the moment.

Q231 Chair: When I met with nurses in Birmingham, one thing that came across very clearly from a number of those who spoke to me was summed up by one who said that she goes to work every day worrying about her PIN because she felt that the impact of staffing shortages meant she just was not able to do her job properly. That has come across very powerfully from a number of witnesses to this inquiry.

Professor Jane Cummings: That is something I would recognise. Both Ruth and I spend a lot of time out in organisations talking to frontline nurses. It is one of the parts of this job that is really important. It is not about sitting in an office in London; it is actually being out with staff. We see it, we hear it, and we talk to people about what they do and what their concerns are. Through the work that Ruth and the team are leading on the retention collaborative, some of that evidence is coming through to them as well.

Q232 Chair: You have heard that message loud and clear.

Professor Jane Cummings: We have heard the message that staff are working under huge pressure. We have heard the message that they are concerned about going into work and having the right number of staff to be able to give the care that they want to give. We are not seeing the impact in terms of what patients are saying, things like the survey results, the replies, the returns that we are hearing, but we do know that people are working. You see it every day. There is also a huge amount of really good stuff going on and it is important that we focus on that too.



Q233 **Chair:** Of course, and we absolutely accept that too.

Professor Jane Cummings: There is an increase, as you have heard from Ian and others, in the number of nurses who are working; it is just not as many as we would want to see and as many as the organisations, the hospitals and the communities are saying that they have funds to be able to employ.

Chair: Ben has a follow-up point.

Q234 **Mr Bradshaw:** Are you talking about nurses actually working physically on wards? What was not clear, in my view, from the first witness was that he talked about this increase but then admitted that there were almost the same number of vacancies. Are we talking about nurse posts that are vacant or real nurses on the ward?

Professor Jane Cummings: I think we are talking about both. We have an increase in the number of nurses who are working in the NHS, but we have also seen a big increase in the number of posts that have become available for nurses, and it is the gap between the numbers of posts that are available and the numbers that are filled on a regular substantive basis.

Q235 **Mr Bradshaw:** The figures he gave us were almost the same, which would imply that there has been no actual increase of nurses on the wards at all. There has been an increase in posts, but they are vacant.

Professor Jane Cummings: There is both. As Ian talked about, there has been an increase in the number. If you look at the information from NHS Digital and the information that HEE and NHS Improvement collect, there has been an increase in the number of nurses. We have also had an increase in the number of posts, and that is fundamentally as a result of the work we started in 2012 when we highlighted the impact on nursing and how many gaps we had. That was before Francis reported.

Q236 **Chair:** We can return to clarify that because Professor Cumming is coming back for the final panel.

Ruth May, could I turn to you as NHS Improvement? You will have seen the evidence from the National Audit Office that talks about us planning for financial viability rather than planning for actual need. Is that something that you would accept and that you are going to address?

Ruth May: I, on behalf of the chief nursing officer, back in 2013 led a piece of work around the NQB guidance. We set out 10 expectations.

Q237 **Chair:** When you are using acronyms, could you explain them, please?

Ruth May: It is the National Quality Board. I led on behalf of Jane, the chief nursing officer, a piece of work that helped and supported trusts with 10 expectations about what to do with nurse staffing and making sure it was safe for our patients day in, day out. The first expectation was that it was the boards' responsibility, the boards taking those figures and the boards making those decisions about safe staffing with advice from



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their director of nursing and other colleagues. That was really important and led to the boards' accountability and to the boards having transparent discussions about numbers. That then led, of course, to a conversation about finance and quality, and numbers of nurse staffing in the round. I absolutely recognise the pressure that provider trusts are under financially, but I know that directors of nursing, chief execs and boards are taking this seriously with regard to what is important with nurse and midwifery numbers, whether it is a ward in their hospital, a community clinic or within mental health or learning disability services.

Q238 Chair: One thing that has come across again loud and clear from the nurses we have spoken to is a sense that we just need more hands on deck. They are acutely worried about the numbers who are leaving and about the working conditions, but we are going to come on to that in specific detail. Could you say, before we move on to working conditions, what you are going to do to try to alleviate the staff shortages in the short term?

Professor Jane Cummings: That is the nub of the issue we have at the moment. We have a huge amount of work around planning the future, but it is about what we do here and now. That is the thing that we hear from our directors of nursing.

One big thing we are doing, which Ruth's team is leading, is around retention. That is about understanding what is causing not only the numbers of people who are leaving but also the variation in those numbers. Ruth will have much more of the detail. We know across the country that in different parts of the regions you get a huge variation in the numbers that are leaving. It is about understanding the reasons why and then trying to support organisations to become better employers, provide a better work-life balance and better circumstances so that staff feel that they want to stay in the service, which is of course what we want them to do.

Being able to keep the people that we have will have the biggest impact in the short term. That is really important. It is about valuing staff; it is about valuing their contribution and recognising the impact that they have on a day-to-day basis on patients' lives. That is the thing that is really important and that is my responsibility, Ruth's, and in fact it is all of ours. The fact that this Committee is doing a review of the nursing workforce will say a lot to nurses about how important you all think it is too. That is our No. 1 priority.

Slightly tangentially to that, one reason why NHS England funded the fast-track Nurse First programme was because, in my view and in our view, the quickest way to get a registered nurse into the system is to do it through a postgraduate programme. These are already graduates. They are able to deliver and come out with either a second degree or a masters degree within two years. That is the fastest way we can do that. It is then working with HEE to make sure that the clinical placements of our current students are as good as they possibly can be and there are



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ongoing relationships built between the providers, whether they be community trusts, acute trusts or mental health trusts, and the universities, so that students who are in training now have a place to go, they have a job to go to, they feel valued and supported, and they know that they are going to have a really interesting career once they have finished. There are several different layers to what we are trying to do now to improve the position.

Chair: Can we drill down more into the issue of retention? Paul is going to lead on that.

Q239 **Dr Williams:** I would not mind a follow-up on a point made a minute ago about the number of vacant posts. Obviously, a vacant post puts everybody under pressure, because, if you are supposed to have five nurses and you only have four, everybody is working a bit harder. Are the posts vacant because they are being advertised and they cannot be recruited to, or is there any evidence that sometimes trusts that are short of money are leaving a post vacant so that they do not have to spend the money?

Professor Jane Cummings: I am not aware of the latter. I think some of it is because people are not available to fill them. There are also some people who are making lifestyle choices and are choosing to do either bank or agency work because it gives them the flexibility that they want. A significant number of the vacancies that we have are filled by people who are doing that type of work. Ruth will have some more of the detail of the retention.

Q240 **Dr Williams:** That ends up costing the trusts more money rather than—

Professor Jane Cummings: For agency it does, but not so much for bank.

Q241 **Dr Williams:** I was going to ask about working conditions, because we have heard that retention is an absolutely key issue. We have heard from nurses and other people that people feel very busy. We have heard the phrase that there is not even time anymore to sit down and have a cup of coffee. How can nurses' working conditions be improved with a view to improving retention?

Ruth May: As Jane, the CNO, has already said, NHSI, my team and I are leading a whole piece of work on retention, which is about how we retain our own people. Part of that work is about looking after the people we have and wanting to make sure that we provide them with the right working conditions and the flexibility, and making sure that we look at them in the whole.

We know that the group in that middle age band—21 to 41—are the ones who want particular flexibility so that they can manage their childcare and have the ability to deal with the whole of family life. We also know from them that they want not just the ease of access for booking their



shifts, not just the ease of access for when they work or how they get paid, but that when they do get work people are looking after them.

The surveys all give us that evidence. Equally, when Jane and I go round to organisations, people tell us that the role of their line manager and the relationship with their line manager are as important in their working conditions as the flexibility. That is really important and is part of the work we are doing round the retention.

We have 53¹ trusts now in cohort 1 in the retention collaborative, which we launched in June 2017. We have fabulous feedback. We have a great start to outcomes. We have some really great examples of organisations starting to address what might be very tiny things but are actually huge things for your nurse.

Q242 Dr Williams: What types of things? What works to show a nurse that he or she is valued?

Ruth May: Oh lots. There are lots of examples around each of the cohort 1s. For example, at Papworth, they are doing a lot of work on rostering, making sure that they are able to do self-rostering rather than being put down for a shift and seeing whether they can fill it. There is work being done in Buckinghamshire Healthcare around some of the itchy feet, making sure that we are looking to have conversations with people before they move, before they go elsewhere, such as, "What is it you want in order to help make this work?" We have University College Hospital in London—UCLH—where Flo, the director of nursing, chief nurse there, has introduced a "football transfer scheme," as I describe it, although she has a better name for it, I am sure. After a certain period of time, somebody is able to put their hand up and say, "I would now like to go and work in this area or get experience of day surgery."

Q243 Dr Williams: It only costs that ward £15 million to buy them.

Ruth May: Sorry?

Dr Williams: I am joking—a football transfer scheme.

Ruth May: Indeed. If there are a lot of people asking for a transfer out of a particular clinical area, it gives some really early signs as to what this now tells us about the leadership, the relationship and the working conditions. I believe directors of nursing are doing some fabulous stuff right now, with some more real-time temperature checks of staff experience.

Q244 Dr Williams: Yet we are still hearing that many nurses feel undervalued.

Ruth May: Yes. You only have to go on to Twitter sometimes to hear about the amount of hours people are putting in and the amount of media coverage where you see some stories about how people are not

¹ The witness has supplied a correction. She should have said '38 trusts' rather than '53 trusts'



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getting cared for. However, we also saw the fabulous TV programme about Imperial recently about how wonderful nurses, paramedics and doctors have been in response to some of the tragedies and the stuff in Manchester and London. The response and the respect that the communities have had for our healthcare professionals have been huge.

Q245 Dr Williams: There is no doubt that the level of public and patient respect for nurses is very high, but you must recognise the picture that people feel stressed and overworked. Is the volume of work that people are required to do a factor in that as well?

Ruth May: I guess it could be. It depends where you are. We know that directors of nursing with their teams have been reviewing staffing—what level of staff and skill mix of staff they need for each shift, for each ward. That is much more transparent now than many years ago. It is much more real time now, so people are doing it not annually but very regularly, shift by shift in places as well.

I know that Jane and Ian have already said this, but we do have a vacancy factor. We know that we have 11% vacancies across England. We know, equally, there are more challenges in London compared with the north-east. We know there are more challenges in the mental health sector compared with acute. It is a very different picture, but, yes, I recognise that of course.

Q246 Dr Williams: Do you have a view on the cuts to nurses' CPD and whether or not they should be reversed?

Professor Jane Cummings: We certainly recognise the impact reductions in CPD funding have had on staff. It is something that helps staff to feel valued and supported. The end of the graduations, the end of their three years, is the beginning and not the end, really. It is a bit like junior doctors. Doctors will qualify, but then they have lots of different opportunities to develop in their careers before they become GPs, consultants or whatever they choose to do, and nurses are no different from that. The ability to continually learn and develop is something that is really important.

Yes, we are concerned about the reductions. You have heard Ian say that we very much want to put more money into that type of service, but I also think there is something else that we can do internally as well within organisations, which is about some of the different types of support. I was talking to a frontline nurse the other day, who said that one thing she wanted was to have time to go and shadow somebody or to have time to go and work in a different environment for a time to learn some different skills and to spend time in a different part of the hospital. There are very different ways we can do it as well as having a formal postgraduate qualification, but it is an important factor and it is one that we hear a lot when we go out and about and talk to staff.

Q247 Chair: You talked about "little things," but one thing we did hear from a



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number of nurses was that they are not even allowed to have a cup of tea on the ward with their patients. Are you looking at things like that? We were even hearing stories of people not having time to have a drink of water on their shifts.

Ruth May: A couple of directors of nursing have just had a recent initiative on absolutely making sure that nurses are having bottles of water and having time to take out. At Guy's and St Thomas', Dame Eileen Sills has introduced a system of absolutely making sure that they have time for a rest and time for breaks. We need to do more on that. That wellbeing element is part of the retention programme. There are some great examples that are starting to be spread, but nurses, like any of us, absolutely need to make sure they have sufficient breaks in order to do a safe job for their patients.

Q248 **Chair:** On the cup of tea point, it has been a source of great resentment among NHS staff that they are not able to have access to that on the wards in the way that they used to. Why did that happen and are you planning to review it?

Ruth May: I do not know why that happened. There are many organisations that are making sure that their staff have enough hydration day in, day out. Jane and I will need to pick up after this how we talk to our directors of nursing about that.

Professor Jane Cummings: One of the pieces of work that NHS England has done is to look at health and wellbeing of staff. We have been really clear that this is vitally important. We have introduced a CQUIN, which you have all heard of before, particularly around health and wellbeing. It is staff saying that their health and wellbeing is being looked after. That is based on the staff survey results, so there is funding going into hospitals that are able to do that. We also have done quite a bit of work on access to appropriate food and drink—not just chocolate bars and sugary drinks, but access to proper food and drink for people, and increasing the uptake of the flu vaccine.

Q249 **Chair:** And the breaks to be able to consume them.

Professor Jane Cummings: Exactly.

Q250 **Dr Cameron:** Staff have also been saying that at times they feel they are not able to spend sufficient time talking to patients. Meeting clinical needs is a priority, obviously, but there are also psychosocial needs, and it is really important that staff have appropriate time to interact with patients to find out how the patients are feeling and to be able to follow that up with them in an appropriate way. How do you feel about that?

Professor Jane Cummings: We would agree. It is a critical part of the role.

Q251 **Dr Cameron:** Is that something that you feel should then be addressed more comprehensively than it is just now if it is a concern that staff are



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raising?

Professor Jane Cummings: From my point of view, yes, if it is a view that is being consistently raised by staff and that is really important to address. When we talk to people and look at what they are doing in their wards or communities, we see that they are spending time talking to patients and that they have an opportunity to do that with both the families and the carers, because that is also really important. It varies, and, as with all these things, it is the variation and the changes on a day-by-day basis and on an organisation-by-organisation basis that mean it is quite hard to generalise. But, certainly, as a principle, yes, one of the brilliant things about being a nurse is your ability to look at the whole patient, the whole person and their family, and that is as much about the psychosocial as it is the really complex, competent, highly skilled clinical experts that they are.

Chair: We have a quick follow-up from Andrew.

Q252 **Andrew Selous:** Without labouring the point, it was not just hydration and breaks; it was having the time to sit down, maybe just for a minute or two, to have a cup of tea with a patient. This was put to us by nurses last week. Has that been forbidden on health and safety grounds?

Professor Jane Cummings: Not that I am aware of, no.

Q253 **Andrew Selous:** So that would be fine. You, as chief nursing officer, would—

Professor Jane Cummings: It would depend on some of the patients and the environment you are in, clearly, if you have a very hot cup of tea, but—

Q254 **Andrew Selous:** Should there be a blanket rule against it?

Professor Jane Cummings: I am not aware of any reason why we would completely ban somebody having some social contact, which will include helping people to drink their tea and eat their food.

Chair: But having a cup of tea with them is the point.

Q255 **Andrew Selous:** Yes, sorry. It was actually sitting down.

Professor Jane Cummings: I am not aware of it. It seems a bit wrong.

Chair: It may seem a small point, but small things can make a difference in making you feel valued in your workplace.

Q256 **Andrew Selous:** If you say you are not aware of it, the nurses that we spoke to last week felt that there had been an edict from on high that they could no longer do it. That was what they very clearly said to us.

Professor Jane Cummings: It is not an edict from me as the chief nursing officer, so I will look into it.

Andrew Selous: That is clear. Thank you.



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Chair: Ben, we are going to move on to Brexit.

Q257 **Mr Bradshaw:** What has been the impact on staffing of the Brexit referendum?

Professor Jane Cummings: We know that the number of EU nationals who have applied to join the NMC register has reduced by something like 89%. We hear that there are a variety of reasons for that. One of them is the language test that was introduced at about the same time as the Brexit vote. There is no doubt that among some of the EU staff to whom we speak how they felt in terms of being welcome in this country had an impact. The third thing we have heard—again, this is anecdotal and I cannot prove it—is that the value of the pound has meant that they are not getting the same amount of income against the euro as they were. There are three key things there.

About 7% of the nursing workforce are EU nationals, but that varies quite significantly. The north-east of the country has very few; London has a significant number—very high numbers. There are something like 20,000 EU nationals who work in London. We also know that in the social care sector it is even higher. In this country we have always employed healthcare workers from overseas, whether in the EU or outside the EU. That is really important. We are a multicultural society. We have people from all over the world who live and work in this country. It is really helpful sometimes to have that, and we can see the positive impact on patient outcomes. My team and I have been very clear that we are continuing to welcome, and want to welcome and support, our current EU nationals, and we would like to see clarity for them as soon as possible.

Q258 **Mr Bradshaw:** Is it possible for you to be clear in disaggregating the reasons, though, between the language test and Brexit, because we have also heard that, as well as an 89% to 90% reduction in applications, there has been a 70% increase in EU nationals leaving—existing staff—from the NHS? That is not likely to be because of the language test, is it?

Professor Jane Cummings: No, because they are already here.

Q259 **Mr Bradshaw:** Is it possible to say of that number that it is clearly Brexit related?

Professor Jane Cummings: No. I do not have that level of breakdown and I am not sure the NMC has that level of breakdown. They ask people why they have left. That is where we have heard the three sets of reasons.

Q260 **Mr Bradshaw:** Janet Davies of the RCN said that she thought that, given the existing challenges in the workforce, Brexit, if it happens, will be devastating for staffing levels in the NHS. Is that an analysis that you share?

Professor Jane Cummings: We would say that we are concerned about what appears to be the impact in terms of the reduction of the people



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applying to join. As I say, we have always had staff from overseas. Overall in the NHS, it is about 5% of the workforce.

Q261 **Mr Bradshaw:** What do you think the Government should be doing to address this?

Professor Jane Cummings: It is a decision for the Government to decide what they want to do as part of the negotiations, but I would be very keen that as soon as possible we are able to give clarity to those staff who want to come and work here, and those staff who are already here in order to make sure that they feel supported to remain.

Q262 **Mr Bradshaw:** Are you, as chief nursing officer, making your views plain to your political bosses on that important matter?

Professor Jane Cummings: We talk frequently about the need to retain the staff we have, and obviously our European nationals are part of that.

Q263 **Mr Bradshaw:** Are you confident that at the very highest levels of Government they understand that?

Professor Jane Cummings: I would sincerely hope so.

Mr Bradshaw: Thank you.

Chair: Thank you. We are going to come on to international recruitment more widely and Andrew is leading on that.

Q264 **Andrew Selous:** Should international recruitment of nurses be done nationally?

Professor Jane Cummings: Yes.

Q265 **Andrew Selous:** Are we taking steps to make sure that happens?

Professor Jane Cummings: Yes, we have started to take steps, as you have heard from Ian.

Q266 **Andrew Selous:** That was in Harrogate, was it not, so it is going to spread out? Bedfordshire is a bit of a way from Harrogate, so I am hoping it might find its way down the M1 at some point.

Professor Jane Cummings: You never know. You would hope so. To be fair, it was something that we suggested a couple of years ago. At the time there was, I suppose, less clarity about that, and some organisations preferred to say they wanted to do their own. We did talk about it about three years ago. There is now a general recognition that doing it once and doing it nationally is the right thing to do, and I really welcome that. HEE has offered and has started the earn, learn and return programme, as you heard from Ian. That is a really important thing for us to do: do it once and do it well.

Q267 **Andrew Selous:** In terms of the projections, are you satisfied that it is ambitious enough nationally to meet the challenge? It sounds as if it is starting quite small with 5,500.



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Professor Jane Cummings: We know we could do more, so I think—

Q268 **Andrew Selous:** Could it be scaled up reasonably fast if it is a model that is proven to work?

Professor Jane Cummings: I would hope so. Ian referred to the workforce strategy. As part of that, when we look to the future, what does that mean in terms of our international recruitment? That will also mean that, when we have an understanding about how many we need or how big we should be, we will also need to think about what advice we then give the Migration Advisory Committee around nurses remaining on the shortage occupation list, which they are at the moment, until 2019.

Q269 **Andrew Selous:** You mentioned a moment ago the problems caused by the new language test. Do you believe that the changes that have been made have adequately addressed those issues?

Professor Jane Cummings: We would want to monitor it quite carefully. We have heard that it has had an impact in terms of the numbers that are now potentially applying. The big change was the one that allowed the occupational English test, which means it is much more clinically focused than the previous test or the IELTS test; it is much more positive for staff. We also think that recognising that people who have either taken their degree in English or have been working in an English-speaking country do not have to do the same thing should also have an impact.

Q270 **Andrew Selous:** Broadly, as to the outcomes for the test to which the changes have been made, are we keeping more nurses here whom we should be keeping as a result of the changed test?

Professor Jane Cummings: It is probably too soon to say because the NMC has only recently made that decision.

Q271 **Andrew Selous:** You are watching that very closely, are you, because it is a serious issue?

Professor Jane Cummings: Yes.

Q272 **Andrew Selous:** We have heard about what we are doing nationally. We heard last week about what Germany is doing. That seems quite an ambitious programme with the Philippines in terms of nurses training there, knowing that they are going to be coming to Germany, and it includes German language training and German clinical language training. Have you studied the German scheme to make sure that ours is at least as good, if not better?

Professor Jane Cummings: No, I have not, but the Philippines is one of the countries that HEE is looking at, and we know that in the Philippines they do often train specifically because they know that their nurses will come over to the UK. It is something we can look at. I have not personally looked at it yet, but HEE might have done.



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Andrew Selous: I think that would be helpful; thank you.

Chair: Finally, we are going to come on to STPs and local workforce planning, and Lisa is going to lead on that.

Q273 **Dr Cameron:** A review by South Bank University published in May this year found that two thirds of STPs—30 out of 44—have no detailed workforce planning. Are you concerned that two thirds of STPs have no detailed workforce plans?

Professor Jane Cummings: I think, yes, initially, but, as we move forward, one thing we are really keen on is that workforce plans should be locally based but also in a big enough footprint to become meaningful. Together with HEE, who have a system in place, they have regional teams in place who can support the STPs in those workforce plans. It will only be iterative, but I would expect them to be much more defined in the future going forward. But, for me, I would much rather see workforce planning that looks at a whole area of work and thinks about the whole system rather than looking at individual organisations, because we know that for patients and for the people that we care for it is the system that matters and not the individual organisation. That is really important. I think we have the potential to do much better with this.

Q274 **Dr Cameron:** As to where we have come from, it sounds as if in terms of previous plans it has not been sufficient. It sounds as if in some cases there have not been plans and in other cases they have been too locally based. Is that what you are saying?

Professor Jane Cummings: This is probably more a question for HEE than for me, but there is a shift in the way that we have previously done it. In the past, workforce plans were traditionally done by providers. An organisation would say, "This is what we think we need," and then they would let people know. Now, we have not only a plan, so you will know about the plan that HEE published around the mental health workforce, for example, which was a big plan that says, "This is what we need," but the reality is that, if we are looking at place-based commissioning or commissioning for people in a footprint, however big or large that is—so an STP footprint—it makes much more sense to look at the whole system, the number of providers, the number of community services, the number of patients, what their particular needs are, and then understand what the workforce needs are for that. That is not just nurses; that would be everything. I do think having a workforce plan on a bigger footprint that looks at that level of detail is much more appropriate as we move forward.

Ruth May: It is also something that has come out of our cohort 1 work on retention. In some areas, there is feedback from staff saying they would quite like to be able to go and test what it is like to work in mental health, or test what it is like to go and work in a different environment, not necessarily permanently but just to get the experience. Through an STP footprint, we were able to do that. We were able to second people



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much more easily. It is much more local for the nurse who wants a different experience, and of course it is much more beneficial for local trusts. As a side effect of that, of course, it is a great working relationship and building relationships across organisations at a very local level.

Professor Jane Cummings: That is also between health and social care. We are actually working on a staff passport, for want of a better word, which respects the individual rights, roles and responsibilities of staff but allows them to move between different organisations in a way that is safer—they feel safe to do that. We are developing that at the moment. They have already piloted that in one part of London, around UCLH, but we are looking at that on a national footprint. That will make a big difference because it will give staff the confidence to move around and it plays back in to the retention issues around giving people the opportunity to learn and develop in different environments, which is not just about going on a course.

Q275 **Dr Cameron:** We have heard repeatedly at the Committee about difficulties for patients and families in accessing autism diagnoses as a particular example. Do you think the workforce plans will start to look at the detail needed in terms of who you require at different locations for specialist autism diagnosis and treatment and that type of work to ensure access?

Professor Jane Cummings: It is a good question. I think we would need to look first at what that would mean. I know there is quite a lot of pressure to do more to diagnose autism earlier. At the moment we are looking through whether that is done through our mental health workforce team or through some of our learning disability teams, but we would need to address what the need was and then look at what that would mean in terms of affordability and funding.

Q276 **Dr Cameron:** It sounds as if you are still at a very early stage of doing that.

Professor Jane Cummings: Yes, we are, with that.

Chair: Thank you.

Q277 **Andrew Selous:** I love the idea of the staff passport; it sounds a brilliant idea. Two specific issues related to that were put to us by nurses from all over the country last week. One was the issue that currently they have to retrain when they move from trust to trust. Would your staff passport idea get rid of that? The second one was the fact that, when they change specialisation, they lose a lot of salary, so that is a big disincentive to do that. Is there anything you could do on those two issues?

Professor Jane Cummings: As to moving—again, Ruth might want to come in on this as to the retention work—if you have been passed as competent in a certain field of practice, and we have more and more standards that are transferable, then I see no reason why that cannot transfer so you do not have to do it again.



Q278 **Andrew Selous:** It is not happening at the moment; that is what we were told last week.

Professor Jane Cummings: It is in some places, but it will depend on what it is, because there are quite a lot of different things. For example, if you have a nurse who is able to administer intravenous drugs in one organisation, and then they have to move to another one and they have to go through the training again to do it, that is, frankly, silly. There are some things that we know we can do and the staff passport will help to recognise those.

Again, Ruth might have more information, but on your point about moving from one specialism to another and then having to take a pay cut, I would need to understand a bit more about the detail. If you have somebody who is a registered mental health nurse, who then moves to work in an environment where they are not using their mental health skills or they are going back to using adult skills that they had some time ago, there may be a short time when they cannot work at the level that they were at because you would expect them to be more competent in that particular field; but I am not sure I would see that as being an automatic thing unless you have experience of it.

Ruth May: Again, when I was visiting UCLH about the football transfer scheme, there were examples there where some people have gone down from a band 6 to a band 5 in order to get experience, but have gone very quickly back up to a band 6 because they have brought that extra experience—

Q279 **Andrew Selous:** I am just putting to you that it was put to us by frontline nurses that it was a disincentive, so maybe it is an area to probe a little further into.

Professor Jane Cummings: We can do it through the retention work.

Q280 **Chair:** Can I clarify one point? You have said it is clearly silly for people who, say, have an IV certificate not to be able to use it in another area, but whose job is it to make sure that this is not happening, because we have heard that it is not happening in some areas but it is in others? Whose job is it to sweep that away and make sure that we get nurses when they change jobs being able to immediately carry out roles that they have been carrying out perfectly competently and safely in another trust? Ruth, do you want to comment on this?

Ruth May: Yes, I would like to. We have some examples now where trusts are coming together. Jane and I spent the day with hospitals in Basildon, Southend and mid-Essex coming together. Their chief nurse, Diane Sarkar, is trying to harmonise not just out-of-hours pay and the rest but also things about being able to work in other areas. If you were working in Basildon in ITU, you would also be able to work in mid-Essex and take those course trainings with you. All of that needs to be done at the local level by directors of nursing. So it is being done.



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Q281 **Chair:** Why does it have to be done at local level? Why could it not be something that you take on as NHS Improvement and say this is clearly wasteful of staff time and money? Could that not be driven at national level, and whose job would it be to do that?

Ruth May: Let me test that with directors of nursing as a result of this meeting. Let me take that away and talk to them, and see what they think. We have done that in London more than anywhere with Capital Nurse, where London is probably further ahead. The new chains of hospitals are, I guess, working on that as well, but, yes, we can take that away.

Q282 **Chair:** It must surely waste a huge amount of NHS resource to do this.

Ruth May: Yes.

Chair: Sometimes nobody identifies whose job it is to get it done, so perhaps you could write to the Committee and tell us whose job it is. Lisa has a final point and then I promise we will move to our next panel.

Q283 **Dr Cameron:** This is just a clarification on nursing staff being able to train in different specialties and moving bands. Would that mean, in practicality, that if they moved specialty they would have to accept a job at a lower band, and then eventually retrain and apply for a second job at a higher band, or is there flexibility within the system if they are recruited to a job at the same band that they could be paid at a slightly lower band until the training was up to speed?

Professor Jane Cummings: I am not sure that there is a simple answer to that because I think it depends on what examples there are.

Q284 **Dr Cameron:** It seems to be acting as a barrier to people moving into other specialties where there is a shortfall, such as mental health and so on.

Professor Jane Cummings: I met a nurse the other day when I was at an event in one of the trusts up in the north of England who had just been promoted from a job that she was in, which was the midwifery specialty—so she was an adult nurse and a midwife but had worked in midwifery for a very long time—into a matron's job in acute medicine. You could say that that is a completely different specialty, but she had moved from being a senior midwife to being the matron looking after a group of medical wards, and she had got that job based on her leadership skills—her ability to lead, influence and support others. So, I do not think it is always the case that you move from one specialty to another and have to take a pay cut.

If, however, as Ruth said, you are a registered mental health nurse or an acute nurse who is an absolute expert in one field of practice and you want to go and do something completely different, in order for you to get up to speed with that, you might either want to do something that is like a day release to that part of the system to get your skills up and then



move across at your existing level, or you might go for a short time on a slightly lower band just so that you can get your skills up to the level that you would want to be able to go back in at a higher level. It really does depend on the individual cases. It is too complex to give a straight answer.

Q285 Dr Cameron: But there should be flexibility within the system to mean that people do not have to take a job at a lower band and then apply for a subsequent one at their existing band.

Professor Jane Cummings: I think, in principle, yes, but bearing in mind there are half a million nurses in England doing different jobs, obviously, and hundreds of different trusts, we would have to look at what the individual circumstances were for some of that. I am not saying we would say absolutely not, that you cannot possibly ever drop a band, but, on the other hand, there should be flexibility around people's individual skills, experience and now enabling them to be able to learn and develop.

Going back to the point I made earlier, the critical thing for staff is to be able to feel that they are valued and that they are given an opportunity to learn and develop, and we need flexibility in how we do that.

Chair: Thank you both very much for coming this afternoon.

Examination of witnesses

Witnesses: Mr Philip Dunne, Professor Jane Cummings, Professor Ian Cumming and Ruth May.

Q286 Chair: Welcome to you, Minister, for joining us this afternoon. The rest of the panel have already introduced themselves. Could I start by reflecting back to you, as I did with the first panel, the quote we had from Sir Robert Francis where he said that huge numbers of staff are working in, frankly, unacceptable and unsafe conditions? Do you recognise that description and how confident are you that patient care can be delivered safely in the face of the current substantial workforce shortfall?

Mr Dunne: I do recognise that the whole of the NHS is under considerable pressure as a result of inexorable demand growth, and that expresses itself to various degrees around different parts of the system. I do recognise that our nursing staff are under considerable pressure and that is why we are seeking to relieve that pressure in a number of different ways, not least in recruiting more nurses into the system over the short, medium and longer term, and looking to find new routes into nursing and new models of care to spread the load across the entire workforce in the NHS.

Q287 Chair: We heard a clear message that we need more hands on deck. That is how it was articulated very clearly to us.

Mr Dunne: To be fair, we have absolutely recognised that, which is why last month we announced a 25% increase in nurses in training, starting



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next year, and why we have introduced these new roles to support registered nurses, in particular the nursing associate, which we may come on to talk about.

Q288 Chair: Do you recognise the concerns expressed in the MBRRACE study published yesterday about the impact on patient safety of some of these workforce shortfalls?

Mr Dunne: We were both there during the statement that the Secretary of State made earlier today about a maternity safety strategy. That is a really important piece of work. We will be launching some consultations on the back of that. As far as it relates to workforce, we have 1,600 more midwives working across our maternity systems since 2010. We have more midwives in training than we have ever had before. It has been at a fairly steady level. It is just over 2,600 currently, and we absolutely recognise that there is continuing pressure on that part of the NHS, as there is on others.

Chair: One challenge that we have to face in workforce planning is that there are so many moving parts at the moment. We have the impact of bursaries and new routes into nursing, Brexit and challenges around retention. We are going to try to drill down into some of those now, starting with Caroline.

Q289 Dr Caroline Johnson: I have one question on staffing levels. We have heard from a number of people that there is a shortage of nursing staff, but no one seems to be able to quantify how many nurses we are short. I know from my experience that some wards, such as neonatal intensive care and other forms of intensive care, have specified safe staffing levels, so we know how many nurses we should have, but that does not seem to be the case in all wards. What work are you doing on identifying how many nurses we actually need, and, bearing in mind the demographic, morbidity and immigration changes and that the NHS is a demand-led service, how do you work out how many short you are and how many you are going to need? Is 25% going to be enough?

Mr Dunne: It is definitely the case that since Sir Robert Francis's report there has been a big focus on increasing the level of nurse staffing in our hospitals and we have had some success in that. Since 2010, there are currently 10,100 more nurses on our wards than there were before. Various strands of work are being done now to look at whether it would be clinically appropriate to specify ratios of nurses to patients across different activities, and at this point those studies are concluding. We do not have the output of that, but we will do at some point in the new year.

On vacancies, the Committee is right to focus on this. It is something that we are looking at and about which I have some concerns, because there is not an acknowledged dataset at this point that gives clarity about the actual vacancies as opposed to the proxies that people are using. The proxy that is most frequently used is the number of NHS job adverts. That in itself gives rise to a number, but it is not particularly useful



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because you may have job adverts running by trusts in perpetuity because they know they have a turnover of staff, so it does not necessarily give you an accurate figure at any point in time. The advert may be for a number of jobs, so there are pluses and minuses for that.

The latest information that I have, which is based on some data collected by NHSI in September, coming from NHS Providers' information, suggests that there are about 36,000 clinical posts that had not been filled by a substantive member of staff, and, of those, some 33,000, both nursing and midwifery vacancies, are covered by bank and agency staff. The figure that has been used of around 40,000 does not take into account the shifts that are filled by a large number of both bank and agency staff, so the actual number of vacant posts on shift is much reduced. I have commissioned some work from NHS Digital to seek to get a metric, a dataset, so that we can get a handle on what the actual vacancy level is across the NHS.

Q290 Dr Caroline Johnson: We heard earlier that some nurses choose to work on the bank because it offers them the flexibility that being substantively employed does not.

Mr Dunne: Indeed.

Q291 Dr Caroline Johnson: I want to move on to ask some questions about the nursing associate role. How would you respond to concerns that were raised by the RCN and others that nursing associates could be used to substitute for nurses? Separately from that, are there examples of roles currently done by degree-level nurses that could be done by nurse associates instead?

Mr Dunne: Can I start on this? I am really pleased that I have the opportunity to talk about this a little bit. I have taken a considerable interest in this role, supporting the work that HEE has done, and, although perhaps this is not the right place to do it as it is in public, I would like to congratulate HEE for putting in place at speed quite a complex new route into nursing. We had a conference last week at which both Ian and I spoke, at which we were taking stock of the first year of this programme.

It is absolutely designed to support the role of registered nurses and not to substitute. The intent, which is being borne out in practice, is that nursing associates will receive on-the-job training with an academic component, which is a significant component, of worked experience across a wide range of settings for two years, which will take them to their first year—their foundation year—of a nursing degree. When it was originally established, we did not know how many of those going on the programme would be likely to want to become registered nurses, and we still do not know that yet because it is too early. But, anecdotally, it looks as though a higher proportion than we had guesstimated are likely to want to train on to become registered nurses, so this is a potential route



into nursing that could deliver significant numbers of registered nurses in due course.

The reason why this is such a valuable programme is because it is providing career opportunities for people who are committed to the setting in which they are working by and large. They are healthcare support workers of a more mature age than is typical for people coming into registered nursing training programmes. They are rooted in their communities; they are likely to want to continue to stay to work in that hospital, if it is a hospital setting, and to serve the community of which they are a part. Therefore, from a retention point of view, I think we will find—although again it is too early to tell—that the nursing associates will be much more inclined to stick with their employer or within the region in which they are working than registered nurses, who are perhaps more mobile, particularly the younger cohorts, once they conclude their training. That is very valuable, and that is what the employers are finding so useful from this role. They believe that too.

From the individual's point of view, it is a sort of glass-ceiling breaking moment. Healthcare support workers who were stuck on the pay structure, on the role that they are undertaking, now have the opportunity, if they want, to go on to become registered nurses, to achieve the same academic qualification as taking a conventional route into registered nursing but to do so over a period of time that suits them. I am not saying they are all going to go straight on into registered nursing. They might want to spend time as a nursing associate and then decide over time whether they want to train.

At this event last week—there were 400 or so people present, and a large number of them were nursing associates from all over the country— I met an individual who had spent the first 32 years of his career in the RAF. He was a 60-year-old man who wanted to get into a caring career and was doing this as a second, if not third, career in fact. I found it somewhat surprising and rather inspirational that people see this as a route into providing patient care that would not have been open to them before.

Q292 Dr Caroline Johnson: That is all great news, but the question really was about substitution and their role relative to the role of the registered nurse. On which occasions could you see the nursing associate being asked to do a job that is currently undertaken by a registered nurse but perhaps does not require his or her full range of skills, and what sort of numbers do you think that would be in terms of reducing demand for registered nurses?

Mr Dunne: I would like to ask one of the nurses to take that one.

Professor Jane Cummings: It is really important that the nursing associate is a role that will support the registered nurses. We are really clear as a group of senior clinical nurse leaders that this is not a substitute, and all of us—NHSI and NHSE—have said that. It means that



it can alter the skill mix in a ward. So, rather than potentially increase by many more registered nurses, you might keep the same level but have some nursing associates alongside. I would not say it would reduce massively the demand for RNs, but it will give a better richness to the skill mix in terms of people being able to do more. You would not necessarily say that a nursing associate could take the role of a registered nurse, but there may be parts of that role that could be done particularly under supervision or under the delegation of a registered nurse.

We know that there are draft standards that have been written and that the universities that are currently providing that support are using those. It is a draft. We will be evaluating it as we go along, and I think the role of the nursing associate will change depending on the setting in which they are working. It will depend on whether they are in general practice, in a community setting, in a nursing home, or potentially whether they are in an acute hospital or a mental health hospital. We should not get too fixated on exactly what we can or cannot do and make it a generic statement. This is about developing people to work as clinical support workers who are working at the top of their licence, before they go on to become a graduate nurse, who are there to support the role of the registered nurse and to support the care of patients.

That is really important, as is having a career pathway for people who currently go in as a healthcare assistant, giving them an opportunity to develop and enhance their skills. As the Minister said, they may stop at nursing associate or they may choose to go on to become a graduate registered nurse. Either of those is fine, but it does give us an opportunity to enrich the skill mix and to do things differently, and I think that is really important.

Q293 Dr Caroline Johnson: An example that was given to me is the nurse who worked in the outpatient clinic. We would recognise that, say, in a neonatal intensive care unit such as I used to work in, the nursing associate is not necessarily going to be taking the place of the nurse who is going to be giving IV drugs and that sort of thing, but in an outpatient clinic setting, where the nurse is greeting and talking to patients, weighing and measuring the patients before they are seen by the doctor, could that role potentially be done by a nursing associate, and do you see that as, essentially, a less expensive alternative to the graduate nurse in that setting?

Professor Jane Cummings: I would imagine so, but I also think that the role of nurses in outpatients is often now, and should often be, more specialist in nature, so that they are using their clinical expertise to support people who are potentially being told something by the team; they are taking them through clinical treatment options; they are—

Q294 Dr Caroline Johnson: But they are a different set of nurses.



Professor Jane Cummings: Yes, that is potentially a different skillset, whereas if you have somebody who is potentially acting as a care co-ordinator, providing access to different levels of information without having to use a graduate profession to be able to use that clinical expertise, then either a healthcare assistant or a nursing associate could work in those environments.

Q295 **Dr Caroline Johnson:** My final question is, what proportion of the nursing associates are coming from healthcare assistants, and what work is being done to ensure that those healthcare assistant posts are being backfilled?

Mr Dunne: Can I have a go at this? In the first two cohorts, the first 2,000 places, there were 8,000 applicants. Virtually all of them were from healthcare support workers who were already employed within the settings in which they were offered the place. The recruitment of healthcare support workers has continued to grow during this period. If you like, they are upskilling healthcare support workers but it is not stopping the flow into healthcare support as a career.

Q296 **Dr Caroline Johnson:** You do not see there being a backlog.

Mr Dunne: No.

Professor Ian Cumming: Adding briefly to what the Minister said, that is absolutely right. We also hear that those organisations that have been part of the pilot scheme are finding it easier to recruit healthcare support workers because they see themselves as having the potential to be able to progress in their career because they know they are part of this pilot group. The other point, perhaps going back to a conversation that we had earlier about retention, is that the most recent data that we have showed that 95% of the nursing associates who started training a year ago are still in training, so we are not losing many of these people out of the training programme at all.

Dr Caroline Johnson: That is good news.

Chair: We have Paul now and then Diana.

Q297 **Dr Williams:** Still on nursing associates, are there going to be any attempts to establish the position of nursing associate as a respected profession in its own right? I realise it is a pilot now, but I am thinking about how important it is to help the patients and the public understand to whom it is they are talking.

Mr Dunne: As you will be aware, we are looking to provide this as a regulated cadre, a regulated profession, and the NMC is intending to have completed all of its work so that when the first cohort graduates they will be able to be regulated at that point.

The professional bodies—the Royal College of Nursing, whom you may have spoken to about this—are looking to provide support to this cadre of



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people as well, so we absolutely see that as having a recognised position within the hierarchy and part of the respect. I was going to say, if I had had an opportunity and I will use this, if I may, briefly, that nurses and doctors remain two of the most highly regarded career professions within everything that people do.

Dr Williams: It has been a strange experience moving from being a doctor to a politician.

Mr Dunne: Indeed. I think, like most of us in this room, we are probably headed on a downward trajectory in terms of external respect, but nurses, I am pleased to say, are still right up there, and all the work that the Committee is doing into this inquiry is very valuable. But I hope that you will continue to recognise that it is really important to retain the motivation of this core group of staff, some nearly 300,000 people working in the NHS whom we are respecting. They are highly regarded by the public and we must talk up the role that they do rather than seek to undermine it.

Q298 **Chair:** Do not be in any doubt that we will not be seeking to undermine the profession.

Mr Dunne: I would not suggest that.

Q299 **Dr Williams:** Thank you for saying that. It is really important that that is said. Step one is to regulate nursing associates. How are the public going to understand, though? Are there any plans to do any work with the public?

Mr Dunne: I think we have a job to do, as we get a more diverse set of roles, as we move from a stratification of doctors and nurses that has been well understood for many decades and we move to a much more fluid workforce. We have not talked about the opportunities for registered nurses to become advanced clinical practitioners, advanced care practitioners or advanced nurses. We are moving some of the boundaries at the top and bottom of each category of employee within the NHS, and we are having a multiplicity of different routes into each of those elements and specialties.

That provides some potential for confusion. I accept that, and I think it is down to NHS leadership and the Department to try to provide some clarity over how people will both enter the workforce and then be respected once they are in the workforce. Much of it, I think, will be done at a local trust level or hospital or care setting level through things such as the use of differential uniforms or dress codes and so on. I must say, I visit hospitals every week. Most hospitals have their own distinctive rules about dress codes and it can be quite confusing today as to what level of person you are talking to. Patients, I think, benefit from some clarity about the person they are dealing with. I am pleased to say most organisations now use name badges so that you have the name of the



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person who is looking after you as well as their role quite visibly available to patients to understand them.

Chair: Diana and Andrew both have a quick question, and then we will move on to the next subject.

Q300 Diana Johnson: When we met the nursing associates last week, I asked them about how they had got into nursing in the first place. They said it was all very quickly and a lot of them had seen adverts on the internet or the intranet. With the range of opportunities now to go into nursing with the nurse associates, Nurse First, the usual undergraduate way and the apprenticeship way, what are we doing to offer guidance to somebody who thinks they want to go into nursing? How are we dealing with that? I hope you are not going to say that we are just leaving it to individual trusts. I hope we have a strategy for guiding people into the right way of training.

Professor Ian Cumming: The challenge that you have given me is one that the Minister has also given me previously. We run the careers services for the NHS as part of our organisation, and it is certainly complex in terms of the number of routes and ways in which you can access either nursing as a registered profession or, indeed, a number of the roles that work alongside our nurses.

One thing that we are doing at the moment is working with the organisation NHS Employers to produce an infographic that shows the various routes in. You can come in through the care certificate, through the healthcare support worker route into the nursing associate route and through to become a registered nurse; you can access through, if you like, the traditional degree route, through three years at university; or you could go down the Nurse First route that the chief nurse talked about earlier on. We are trying to describe in an easy way the various different routes.

What we do not want to do at this stage is to consider closing any of those routes off because we are actually getting quite a richness and a diversity in our workforce and in applications by giving people that choice of route. We are also finding that, perhaps if people did not quite get the A-levels that they may need to go in through one particular route, they are now diverting and looking at other options, which we think is good in terms of giving people that choice.

Mr Dunne: But we are looking at an advertising campaign to be launched imminently, in particular to encourage recruitment into nursing. Having increased or expanded the scope of undergraduate nursing places, we want to make sure we fill them, so we have to attract the young people who are thinking about their UCAS applications for next year. That will form part of differentiating the registered nurse role from the others.

Professor Jane Cummings: That also feeds into the work that I am leading on the image of nursing, so actually being really clear that people



understand what nursing is, and that the image is something that is constructive and positive, and it is a career that people really want to join in and to be part of. When we speak to nurses, the vast majority of them say it is a fantastic career, with huge opportunities for them to do lots of different work; it is really exciting; it is hard at the moment—we all know that—but really important. We want to do something that really pushes the image of nursing and midwifery, but really get that out there. The recruitment campaign is a vital part of that.

Chair: Andrew, because Luciana has to leave shortly, can we come to your question after Luciana's?

Q301 **Luciana Berger:** Minister, can you share with the Committee how the recently announced pay increases for nurses are going to be funded and implemented?

Mr Dunne: I am sorry, I just missed that—the campaign?

Luciana Berger: The recently announced pay increases.

Mr Dunne: Yes. There will be, following the Budget, remit letters sent to the pay review bodies—Agenda for Change staff is one of them—and that will set out the Government's position and be followed up with evidence about how we will be looking to reach an agreement with the nursing and other Agenda for Change staff, which will allow a settlement to be, hopefully, agreed in parallel with the pay review body process, at the conclusion of which, if a settlement has been reached, that will be funded, which I think was the point of your question. Any excess over the 1% that is already in our spending review budget will be funded by the Treasury.

Q302 **Luciana Berger:** Do you know when this process will be concluded by?

Mr Dunne: Because we started rather later than normal following on from the general election, the intent is for the pay review bodies to report in May and backdate any award to April.

Q303 **Luciana Berger:** The Secretary of State has said that the Chancellor will consider providing this extra money for nurses if he is able to secure some productivity improvements. Again, we heard from the Secretary of State at the Select Committee that pay rises will be linked to productivity improvements. Where do you expect to find these additional productivity gains from our nursing workforce?

Mr Dunne: We are having discussions with the representative bodies, the unions, about this. I cannot go into any detail of those discussions at this point for reasons that you will understand, but the intent is to look around some of the progression payments and try to find ways of encouraging the banding structure to be adjusted to reflect skills as much as duration.

Q304 **Luciana Berger:** We know that NHS productivity has increased by 1.7% every year, on average, since 2009-10, while economy-wide productivity



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has only increased by 0.2%, indicating that we are seeing quite a lot of productivity within our NHS. Therefore, when we are hearing noises seeking to achieve additional productivity gains above that within our NHS, obviously many concerns are being raised.

Mr Dunne: Productivity obviously is a complex equation.

Luciana Berger: Of course.

Mr Dunne: Part of the reason why the NHS has shown a greater productivity gain than the economy at large is the introduction of technology. Nursing and doctor time can be accelerated by introducing new technologies that cut down the duration of the procedures that might have been done in the past. So, I think there is plenty of scope to increase productivity if we embrace technology and the way in which models of care adapt over time.

Q305 **Chair:** Would you also recognise the need to liaise with colleagues in the nursing home sector about the importance of keeping an equivalence in the community sector as well?

Mr Dunne: We are acutely aware that on the NMC register of nurses there are as many people working, almost, in the UK in other sectors, whether it is the independent sector or in the care home sector, who are registered nurses, and that any settlement that we reach may have some flow-through pressure on the other sectors; so, we are aware of that. We have some representative bodies, employer bodies, who talk to each other, and I will take that up with officials in the Department to make sure that they do have that discussion.

Q306 **Chair:** As you know, there is real concern about nursing home closures and that this could be a driver for further closures if we are not careful about the workforce in the community setting.

Mr Dunne: Yes. I think the recent announcement on the increase in the national minimum wage, which does not affect NHS staff at the moment but does impact on social care, is related to—

Q307 **Chair:** But it is about nurses working in nursing homes as well, and they are not on minimum wage. So, is that something you can assure this Committee you will be having discussions with your colleagues about and that you support it?

Mr Dunne: I can say that we will talk to the representative body that covers all employers of nurses.

Chair: Although the Chancellor has committed to supporting nurses working in Agenda for Change roles, as I say, there is real concern about the impact on nursing homes as well.

Q308 **Dr Williams:** On this point, Minister, are there any plans to introduce any regional differentials in pay above and beyond the current London weighting?



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Mr Dunne: The London weighting is the only one that I am aware of that we have at the moment and it gives rise to some challenges for people who are on the ring just outside London. Mr Selous is nodding his head. It applies all around London. It has a draw. The problem is that, if you introduce a similar weighting anywhere else, then it is going to give the same pull effect away from other parts of the country. I would say that we are very aware of the challenge of recruiting and retaining in the dispersed parts of NHS England, and it is a challenge to encourage people to work in all our settings, and that challenge has in some areas—not in nursing, apart from the London weighting—encouraged some additional payments. For some GPs, for example, there is a scheme to encourage them to go and work in places where they are finding it hard to recruit. I do not think that we are contemplating anything similar for nursing staff at this stage.

Q309 **Chair:** What about nurses working in shortage specialties more widely, such as learning disability and mental health nursing?

Mr Dunne: You were talking earlier about the nursing fast-track scheme, which was initially launched as Nurse First, and that is where HEE has provided funding to recruit specifically into the mental health and learning disabilities cohorts of nurses. That is an alternative to the funding scheme that we have for registered nurses.

Q310 **Chair:** That is on recruitment, but in terms of long-term pay structures is that something you are also looking at?

Mr Dunne: We are not looking at that at the moment. Could I say, if I may, on mental health, as you mentioned it, and nursing associates, that one thing that I was struck by from discussions with nursing associates in the last few weeks is that the experience from people who have been healthcare support workers, typically in an acute setting, because that is where most of them have come from, of working in the community and particularly working in mental health settings, has opened many of their eyes to the opportunity to do that work. I think we will find—I do not know if others agree—that a number of nursing associates will choose to go into mental health as a career, which might help us to fill some of those slots in due course.

Chair: We heard that from nursing associates in training whom we met last week. Now I am going to come on to Andrew.

Q311 **Andrew Selous:** Coming on to nursing associates, and I think you touched on it briefly, but I would welcome clarification, some of the trainee nursing associates whom we spoke to at the Royal London—they were from all around the country actually—last Thursday were very adamant that once they had done their training they did not want to go back to wearing a healthcare assistant's uniform again. You made the point about the badges, but they feel they have put the effort in and done the training, and they want to look different. Has that point been fully taken on board? I am not asking you to give detail now trust by



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trust but just to have some recognition of it at your level, Minister.

Mr Dunne: If I may, that is a good question for Jane or Ruth.

Professor Jane Cummings: They will be different. There will be a healthcare assistant; then there will be a nursing associate who will have a foundation degree and be trained to a certain level; and then there are graduate nurses. So, I do think there should be a differential.

Ruth May: One piece of feedback I have had from trainee nursing associates is whether there will be a national uniform, for example, for nursing associates. That is a question we would have to think about.

Professor Ian Cumming: Could I also add that I cannot overemphasise how proud many of our trainee nursing associates are of the role that they are entering? I have here a badge that Birmingham City University has prepared, that is, a Birmingham City University trainee nursing associate badge, and they have paid for that themselves—they have funded that themselves—as a sign of the pride that they have in the role and the fact that they are taking on further qualifications. It is absolutely critical that we signify that these are people who have undertaken a foundation degree, undertaken that two years of training and have reached a certain level of competence within the nursing team. I think we have to do that.

Q312 **Andrew Selous:** That is very welcome; thank you. Minister, turning to the workforce strategy, when can we expect to see it and what can we expect to see in it?

Mr Dunne: We can expect to see it, to use a parliamentary word, “shortly.”

Q313 **Andrew Selous:** At least you did not say “in due course.”

Mr Dunne: I think it will be more “shortly” than “in due course.” What we are doing—and this is work being led by HEE supported by all the ALBs and the Department of Health—is taking stock of where we are in workforce across the piece, so looking at all elements of the workforce, identifying what are the challenges that we are currently facing. We are calling it “facing the facts,” and then we are suggesting some means of addressing those challenges over a longer horizon than we have typically been used to dealing with, looking at a 10-year-plus strategy. We will be consulting on elements of that during the course of next year.

Q314 **Andrew Selous:** Our information is that 90% of trust chairs and chief executives are worried or very worried about recruitment and retention. I also note that last year the National Audit Office commented on the fragmented arrangements for managing supply of staff and spoke of a risk of duplication and incoherence. Has that been fully taken on board at the Department of Health and are you confident that your workforce strategy will address those concerns and that analysis by the NAO?



Mr Dunne: Part of our response to that analysis is that we do recognise that we need to take a more coherent approach across all disciplines and going out for longer in duration. So, the short answer to that is yes, we do, and we are going to be quite candid about the challenges that we face, which has not always been the case for Ministers in the Department of Health. That will probably give rise to some challenges for us, but we are going to try to meet those challenges by identifying routes to solve the problems that we perceive exist.

Q315 **Andrew Selous:** With regard to European Union nurses working in the UK, what exactly is it that you are doing to give them real reassurance that they are extremely welcome and valued here?

Mr Dunne: As you will have heard from attending every Health Questions since I have been in post, for which I am very grateful, since the referendum, at every opportunity, the Secretary of State has made the point that all non-UK EU nurses and other members of the workforce of the NHS are very welcome and we want to try to reassure them as much as we can. All those who registered to receive information on the state of the Brexit discussions received a letter from the Prime Minister, mostly by email, before the last EU Council meeting reassuring them that the procedures for securing permanent residency once we have left the UK will be simple, straightforward and cheap, and to reassure them yet again that this is something that we intend to provide and that they are very welcome here.

I will give you the latest figures that I have, because I think the impression was given earlier that there has been a very significant exodus, and that is not actually correct. The latest figures that I have are for nurses and health visitors, which are a combined group in our statistics. As at the end of June, there were 21,664 working in the NHS, which was down 162 over the previous 12 months. Since the referendum in June 2016, that is a 0.75% reduction of nurses working in the NHS.

The question was asked about leavers and joiners. It is the case that we have begun to see a slight shift in position with fewer joiners arriving than leavers, but again the proportions are not that different. The figures for EU citizens who were leaving nursing in August 2017 were 2.4% of the total, compared with 2.6% of the total nursing leavers a year previously. The joiner figures of nurses in August were 9.2% of all those nurses who joined the NHS, compared with 11.6% in the prior year. That is the beginning of a trend. As was said earlier, I think quite rightly, by Jane, it is unclear the extent to which that has been the responsibility of the coincidence of the much more rigorous language test that was brought in in July 2016.

There is some work being done by the NMC. It does not have statistics that it can publish yet, but, as you know, it made some changes to the language tests at the beginning of November, at the beginning of this month, and we will have to see what impact that has. The initial



indications are that it appears to be positive, but we cannot give any statistics on that yet.

Yes, it is clearly a more challenging situation than we had, but as yet we are not seeing the mass exodus that is being talked about from the statistics that we have of those who are actually working. The numbers who are joining the register at the NMC are significantly down, but that is not the same as the numbers who are actually working in the NHS.

Q316 Andrew Selous: Looking at the non-EU side of the equation, which we have already talked about quite a bit so far in this session, and looking at the numbers specifically for previous years, if we go back from, say, 1998 to 2007, there really were pretty significant numbers coming in from outside the European Union. I estimate between 15,000 to 12,000 or so at its peak, so that is quite a lot larger than the 5,500 that we have heard about from the Indian pilot. Can you say anything more on the ability to scale up those numbers on what I think you have termed the earn, learn and return scheme, which sounds a thoroughly sensible scheme?

Mr Dunne: Again, Ian might have something to contribute to this, but my sense is that there have been waves of migration of nurses coming to work in this country from non-EU countries, according to the patterns of behaviour in other countries. We have been a big beneficiary of skilled nurses coming to work in this country. There is roughly a similar number of EU nurses and non-EU nurses working here at the moment, and that applies across most disciplines within the NHS. We are focusing, or Ian is focusing, HEE's effort, as he has described, on countries where they have an abundance or an oversupply of skilled nursing—in particular the Philippines and India.

The schemes that we have discussed will make a significant contribution towards replacing them, if we do see a significant reduction in EU people coming to work here, but it is just part of the picture of a wide range of measures that we are trying to introduce to address the short, medium and the long term. We have talked about some of the long-term measures—nursing associates and the increase in registered nurses.

Some of the other short-term measures are improving our retire and return scheme. In the last five years, between 2013 and 2016, the percentage of nurses who had left their posts in the NHS to take their pension and then returned to the NHS has gone from 18% to 23%. That is reasonably significant and an indication that we are encouraging many people who choose to retire from a full-time post—either because they want the flexibility provided by the ability to do that or because there is some sort of incentive for them to do so from a tax or an employment point of view—to come back. That is an important part of the panoply of measures to keep the staff numbers up.

Q317 Andrew Selous: There is just a final question from me, and my apologies as I meant to ask this earlier. Can you assure us that the workforce strategy will consider the social care workforce as an integral



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part of it?

Mr Dunne: There will be significant reference to social care in the workforce strategy. That is our intent.

Andrew Selous: Thank you.

Professor Ian Cumming: May I come back on the 5,500 number for clarity for the Committee? We are expecting that to be a net increase through that additional earn, learn and return scheme. That is not the total scope of the international recruitment plans that we have. That is purely for the earn, learn and return component.

Q318 **Chair:** Can I return to some of the data you have been giving us about joiners and leavers? By joiners, do you mean existing staff or new joiners to the NHS, because there is a very big discrepancy between the data that we have received from the NMC about registrations essentially falling off a cliff and the data you are giving us, which is that there is not much change?

Mr Dunne: We are seeing a change because it had previously been going up, but the change is not as marked as the figures that the NMC is generating. The source of the figures that I have just described is those working within NHS settings.

Q319 **Chair:** When you say joiners, you do not mean new joiners; you mean people who were actually existing staff. Is that right?

Mr Dunne: No; I mean net new joiners.

Q320 **Chair:** Net new joiners. There is still a discrepancy.

Mr Dunne: I am sorry; we do have a difficulty in calculating people who may be on the register, who may have ceased working for the NHS to have a career break but who come back. Our records, I think, are taken from the employment record, if anybody can help with this. Somebody may still be an inactive employee if they have gone on a maternity course, for example. They would not be counted, I think I am right in saying, as a new joiner. These are new employees joining the NHS as employees.

Q321 **Chair:** If you look at the data from the NMC, they indicate there is a very major problem. What we are hearing from the Minister is that there is not a problem, so which is the data we should be looking at?

Mr Dunne: Could I steer you towards the monthly NHS statistics that come out showing across all categories, which is the best guide to what is actually happening in terms of number of employees? This does not capture the EU citizens, but it gives you a picture of the total figures. It is shaped like a hockey stick. At a point when people cease their training and become substantive employees, August is typically the lowest month for nurses because they have not come into employment yet. They start in September.



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Chair: You have to compare like with like; I appreciate that, yes.

Mr Dunne: It jumps up in September and October when people start substantive posts, and then it gradually tails away as people retire. The figure for August 2017 that I have here shows the first decrease—a slight decrease—of 1,505, a 0.5% reduction compared with the previous August, which is the first time there has been a reduction since August 2012, so there has been a steady increase.

Q322 **Chair:** This is the total workforce.

Mr Dunne: That is for the total. As for the EU numbers, they were calculated relatively recently. The last figures that we have to compare are June 2017 versus June 2016, and those are the figures that I have just given you.

Q323 **Chair:** The figures we have—because I think this matters—indicate that there has been a fall. We have entirely different figures, so I think it would be very helpful if, rather than argue about this point in this setting—

Mr Dunne: We will write to you and clarify those for you.

Q324 **Chair:** Can we have a detailed breakdown about how your figures are arrived at, why they are different from the data that we are getting from the NMC, and what you are intending as your recommendations for the workforce strategy as to what is the best way to calculate this, because there seems to be great variation across sectors?

Mr Dunne: They are obviously calculating very different things. The NMC is working off close to 700,000 people who are registered with the NMC. That includes people who are not working in this country who, for whatever reason, initially trained here and are now working overseas, and it includes the other countries within the UK; and it is a much larger pool.

Q325 **Chair:** Indeed. It would be very helpful for this inquiry if we could have a detailed breakdown that makes it very clear how the figures are so different and what you are going to be recommending in your workforce strategy going forward.

Mr Dunne: I would be delighted to do that for the Committee and certainly will write and respond to that question. I am not sure I will be able to give the Committee what we are going to say in the workforce strategy before we have published it.

Chair: No, but perhaps the recommendations from Health Education England then, if you are not able to tell us yourself, would be helpful. Thank you. I interrupted you, Andrew.

Andrew Selous: I have finished.

Chair: We are moving on from there. Now I am going to ask Caroline to



come in.

Q326 Dr Caroline Johnson: I have some questions about CPD. We heard earlier about a reduction in the CPD budget, why that might have been and how that was being directed. I understand that there is a balance between people wanting to do a course and it being necessary or desirable for the NHS for them to have done a course. It is good to hear that you are directing money that you have towards the needs of the wider NHS. As a medic myself, I know that I am expected to go on certain courses every year, every three years or every four years, and that my CPD budget may or may not cover that in a given year, depending on what else I might have needed to do. So, there is an onus on an individual to spend money on their own training, which is again not necessarily a bad thing. What effect do you think this has on retention and how valued staff feel?

Professor Ian Cumming: As I mentioned earlier, investing in the education and training of individuals, and their future, certainly has an impact on morale, and it certainly has an impact on the way that that individual feels towards their employer. Over the last 12 months, as I mentioned earlier, we have not been able to spend as much on a general allocation for continuing professional development to the wider workforce as we have done previously because of the conscious decision to invest in training more of the future workforce; so that will have had an impact.

However, in areas where we have targeted our spend, of which nursing associates is a good example, they are taking healthcare support workers, investing in their education and training. We could count that as CPD or workforce transformation money as well. It is definitely having an impact on their morale and motivation, as evidenced by the retention figures and by the number of people applying, and so on. So, I go back to my earlier answer that it is our intention within HEE to divert as much of our available resource as we can into the existing workforce.

The Committee has heard me say previously that in 15 years' time more than 50% of the workforce of the NHS are currently in employment in the NHS, and, therefore, if we want to transform how we deliver care, we need to invest in the current workforce and not just in the future workforce.

Q327 Dr Caroline Johnson: But, in a way, that is directed towards the needs of the NHS.

Professor Ian Cumming: It is directed towards the needs of the NHS and directed towards our key priorities. If I may be allowed to give you one example that we are putting into the workforce strategy, we are raising for discussion whether we should ring-fence certain areas of workforce transformation money to particular groupings, such as mental health. Should we say that we are going to target a certain percentage of our spend on CPD workforce transformation to the mental health workforce to make sure that we are investing in that area and it is not



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perhaps all diverted off into other areas, which is one of the criticisms that we heard previously?

Q328 Dr Caroline Johnson: Would you like to come in at all on that, Minister? You set the budget for them.

Mr Dunne: We do, and we do recognise that CPD is an important element of, in particular, both skilling up staff—nurses—and also keeping nurses well motivated. It is raised with me as an issue as I travel round wards, and I am sure it has been with the Committee as you have visited hospitals. It has been one of the things that has had to be reduced in order to provide funding for some of the increased numbers. There is a trade-off here between the amount we invest in existing staff and the opportunity to expand the workforce. It is not a linear progression, but there has been some reduction in CPD as a result of that.

Q329 Dr Caroline Johnson: At the moment, the priority is to get more staff in and to direct them into areas of need.

Mr Dunne: I would say that has been the priority, yes.

Q330 Chair: This Committee has expressed concern before about the transfers from the HEE budget into the NHS England budget. Do you feel concerned that, if we find down the line that the impact of bursaries has been that we lose a very valued route into degree nursing, your flexibility to address the bursary will not be there?

Mr Dunne: I do not think we have flexibility at the moment to address the bursary in principle, and we will find out very shortly once the UCAS figures come out—within a matter of days now—what impact it has had. The encouraging thing is that we have so far had close to two applicants for every funded place, which suggests that there is still strong demand to undertake undergraduate training of registered nurses, which is what we need, want and expect to continue to happen, and we need to be promoting the career of nursing and encouraging in particular school leavers to see that as a fulfilling career.

Q331 Chair: Do you have any plans to further change or erode the HEE budget, or do you see it as important to protect it or even increase it?

Mr Dunne: The spending review has set a budget for five years, and at the moment the HEE budget is settled for that timeframe and I do not see any changes to that for the time being.

Chair: Thank you. Andrew, have you covered all the points you wanted to make on workforce?

Andrew Selous: I have.

Chair: We are finally coming to Diana's question.

Q332 Diana Johnson: This is really for the Minister about apprenticeships. We have heard earlier about some of the frustrations with the way the



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apprenticeship levy system is working and a call for perhaps being able to do it in a strategic way across the NHS. Minister, what is your view about how well the apprenticeship levy is working in funding training places for nurses?

Mr Dunne: It is slightly early days as it has only just come in. The way it works is that individual employers provide a percentage of their pay bill into the Department for Education and then they receive vouchers back. It is not designed to provide ready flexibility between different legal entities. There is considerable motivation for NHS employers to secure apprentices to work within their own organisation, because they can then take advantage of that voucher scheme to pay for it, which is then topped up by the Government by an extra 10% for each place that is funded. It is probably fair to say that the way it works has not been as well understood by employers as perhaps it might have been. We need to ensure that employers are on board for these different qualifying apprenticeship programmes to encourage as many people who come in to start in the workforce to be able to take advantage of them.

Q333 **Diana Johnson:** We heard from Professor Cumming about the bureaucracy involved in hundreds and hundreds of organisations having to make applications and get the vouchers, and all of that. Do you see that there is a problem with this in terms of its overly bureaucratic nature?

Mr Dunne: The NHS is the largest collective employer in the country, but it is made up of hundreds of individual legal entities that are the actual employers, and HEE is an employer of doctors in training. Nurses in training are employed by the individual trusts. It is a complex picture because it is an enormous organisation, but each organisation employs a large number of people. In most of our constituencies, our NHS entity is the largest employer or one of the largest employers.

To suggest that it is too complex for these big organisations to manage does not really reflect what is happening in the economy as a whole, because all employers are, if they are above the threshold of £3 million of pay bill, having to grapple with this new mechanism. So, I do not really accept that it is particularly difficult for the NHS. The NHS will be one of the largest providers—if not the largest provider—of apprenticeships under this new regime. What I have hinted at is that we have been a bit slow in getting the NHS geared up to do this, but that will improve over time, I am sure.

Q334 **Diana Johnson:** I do not think I am implying that it is too complex for the NHS trusts and bodies to deal with. I am saying that perhaps a better use of public money would be to have some overarching scheme that could do this in a more cost-efficient way rather than having lots of individual organisations having to do the same thing. That was my point to you.



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Mr Dunne: That is a philosophical thing about whether it is more efficient or less efficient to have larger or smaller units providing healthcare in this country.

Q335 **Diana Johnson:** No; it is about this particular issue of the apprenticeship levy, is it not, and ensuring that the apprenticeship levy delivers what we all want it to, which is to train more nurses?

Mr Dunne: The employers of the nurses are the individual entities, so, to have an incentive for those entities to go out and find apprentices to be able to use the levy that they are already paying I think is the right place for it. If we were to remove it from the individual employer, then, arguably, there would be less incentive on them to go out and find the trainees.

The impression I have, and again Ian will have a view on this, is that there is a strong imperative on employers to fill some of the employment gaps they have within their organisations right across different disciplines, and they see the potential of using the apprenticeship levy as a tool that can be of help to them in filling those slots. I think there will be a bit of a dip in the first year of its introduction, and that will act as more of a stimulus for them to go out and recruit people as the year progresses.

Q336 **Chair:** But we have heard that they have the incentive to go out and fill those places anyway. It is just that it is a very bureaucratic mechanism for doing so and everyone is having to reinvent the wheel, which seems to be the message. Perhaps, Professor Cumming, you would like to come back in on that.

Professor Ian Cumming: It is a different system, without a shadow of doubt. Historically, HEE, or predecessor organisations, would have gone out and commissioned from universities a number of places and funded those through the universities, and then the NHS would have identified people to start on that. The disadvantage of that system is that it does not always have the right degree of local employer, local NHS trust or other body employer buy-in to it happening because it is something that happens for them. The advantage of the new system is that it absolutely is the local employer who is drawing down the vouchers, who is identifying their member of staff and supporting them through it. We would hope that we can somehow just blend the two so that we can keep that local buy-in for the employers, keep the voucher system, but perhaps allow some sort of co-ordination on a larger footprint.

Q337 **Chair:** So it is on a larger footprint, maybe at the STP level.

Professor Ian Cumming: Potentially.

Q338 **Chair:** Thank you for clarifying that. If no one has any more questions, are there any points that any members of the panel wanted to make before they left that they have not been asked about?



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Professor Ian Cumming: I have one thing, if I may. We had a conversation earlier about STPs. So that the Committee is aware, every STP in the country sits either alongside or is part of something called a local workforce action board, and they have been charged with the responsibility of supplying workforce plans down to each individual STP level so that we have something on each STP level across the country. The data associated with that on supply and demand shortage areas is being produced at the moment, but in the next few months every STP will have the data associated with the workforce in their own area to allow them to take their plans forward.

Chair: Next time we return to this, they will be in place. Thank you for clarifying that point, and thank you all for coming this afternoon.