NWF0002

Written evidence submitted by The King's Fund

Introduction

The King's Fund is an independent charitable organisation working to improve health and care in England. Our vision is that the best possible health and care is available to all. We aim to be a catalyst for change and to inspire improvements in health and care by:

- generating and sharing ideas and evidence
- offering rigorous analysis and independent challenge
- bringing people together to discuss, share and learn
- supporting and developing people, teams and organisations
- helping people to make sense of the health and care system.

We welcome this opportunity to provide information to the inquiry.

The National Audit Office (NAO) report, *The NHS nursing workforce* (NAO 2020), set out a balanced picture. It recognised achievements in areas such as improved retention rates and hitting targets for extending apprenticeships. However, it also presented significant continuing concerns, especially in relation to:

- the supply of nurses into the NHS
- workforce planning
- the need for a national strategy with clear roles, responsibilities and accountability.

This submission will focus on these three themes.

Just as the NAO did, we preface our submission with a reminder that although NHS acute and mental health trusts offer the most data to understand the nursing workforce, it is essential that national policy includes social care, primary care and community health services where there is less routine data collection. Each of these sectors employs large numbers of nurses, and each has its own – different but equally significant – nursing workforce challenges.

The supply of nurses

In 2019, together with the Nuffield Trust and the Health Foundation, we published an analysis of the policy levers available to address the shortfall of nurses in England and modelled what they would need to do to eliminate nursing vacancies over a 10-year period (Beech *et al* 2019). Our view remains that this is both a feasible ambition and a better option than the NHS long-term plan's target to halve nursing vacancies to 5 per cent over a 10-year period (NHS England 2019).

However, filling vacancies has clearly become more difficult since the Covid-19 pandemic began. Our 2019 modelling showed the need to increase ethical international recruitment to 5,000 nurses each year for five years, while increasing training places to make England more self-sufficient in subsequent years. That level of international recruitment is currently not possible, despite the government's points-based immigration system including specific allowances to avoid nurses being excluded by its salary requirements, because nurses from the Philippines, India and other countries are unable to travel to the UK because of Covid-19. This means that initiatives to increase training

places in England for nurses, and to make nursing in the NHS a more attractive career, may need to be bolder and faster than previously planned. The Covid-19 pandemic also highlights that England's longstanding reliance on international recruitment is a risky dependency that the NHS must wean itself off.

To improve the supply of nurses, retention must be regarded as equally as important as training and recruitment. Recruiting an additional 50,000 nurses will not solve the workforce crisis unless there are equally ambitious commitments to reduce numbers leaving the NHS – and the recent influx of nurses returning to the NHS during the Covid-19 pandemic means the potential benefit from improving retention is currently bigger than previously. NHS England and NHS Improvement's programme of support for NHS trusts is making progress and we believe that going further still will require a greater emphasis on leadership practices and workplace cultures in NHS organisations. In our engagement with NHS services that are making good progress in staff retention, characteristics such as leaders who listen to staff and act on their feedback, and a culture that promotes compassion above all, supports and practises effective teamworking and values staff by investing in their continuing professional development, are often noticeable features. These leadership practices do not come by chance, they must be visibly led by the boards and senior leaders across health and care including within the arm's length bodies.

The NHS Staff Survey has shown for many years high and increasing levels of stress and difficulty in achieving a work–life balance (NHS England 2020). These trends are mirrored in the reasons that nurses give for resigning from the NHS (NHS Digital 2019). Chronic excessive workloads and high stress levels have too often become normalised in the culture of NHS organisations (West 2020). We believe that workload and stress are particularly important areas in which a more consistently supportive culture in NHS organisations could make a difference to staff retention rates. There is possible learning in this regard from recent experience in the Nightingale hospitals (Lay 2020).

Recent problems in ensuring access to personal protective equipment (PPE) have highlighted a wider issue of lacking or deficient equipment and basic facilities that are important for protecting staff's basic safety and wellbeing. For example, in current research under way at the Fund nurses have raised the absence of basic facilities such as access to toilets when needed, availability of nutritious food and hot drinks, access to drinking water and the ability to take proper breaks for such things, as issues that affect their wellbeing. Nurses often work 12-hour shifts overnight and the absence of basic facilities can have an impact on both physical and cognitive resilience. This finding is in common with a UK-wide review commissioned by the General Medical Council (West and Coia 2019) into the factors that have an impact on the mental health and wellbeing of medical students and doctors and is incompatible with a culture that truly listens to and values staff. Just as there are well-established policies to protect staff from physical assault, we believe that national standards should be considered on basic equipment and facilities to ensure staff safety and wellbeing.

Workforce planning

Long training times and rapidly changing health technologies mean that workforce planning in health care is particularly difficult. The NHS in England has a decidedly mixed track record. The NHS long-term plan and interim people plan (NHS England and NHS Improvement 2019) envisage a significant devolution to local health and care systems of workforce planning functions and responsibilities that have previously often been highly centralised. This makes a lot of sense – but making this shift is not simple and there are risks in how it can be done.

In our engagement with local health and care systems, we have fairly consistently noticed workforce functions with minimal resources – sometimes relying on a very small number of staff who are often 'borrowed' part-time from local organisations, and small, non-recurrent budgets often 're-purposed' from their original intent. Sometimes it appears a picture of scraping together whatever scant resource they can find. Workforce planning requires specialist skills in data modelling and analysis, which we have been told are in very short supply in some areas; possibly, these functions may be too specialised to resource fully in all of the 42 local systems, and arrangements will need to be developed for pooling resource. Local systems appear to vary in how much, and how well, they join up NHS workforce planning with social care (and this inconsistency is mirrored at national level, where the points-based immigration system supports international recruitment of nurses but not the vast majority of care workers). More work is needed to bring together workforce and financial planning, to avoid past tensions between safe staffing levels and cost improvement programmes from re-surfacing. Like the NAO we have observed how important and complex the relationship the NHS has with higher education institutes is and how widely this relationship can vary between local areas with potential consequences for how effectively universities can meet workforce demand in their local health and care system. . With these big questions to address, plus the inherently difficult task of workforce planning to deliver, the 42 workforce leads appear under-resourced and under-recognised as the key leadership group who are managing what is arguably the NHS's single biggest risk area.

National strategy

Delays in publishing the NHS people plan are regrettable but perhaps understandable when – for example as noted above, assumptions about what ethical international recruitment is possible have been fundamentally changing. However, the plan should be published as soon as possible but there are also three matters that are in some ways more important than the timing of its publication.

First, learning from the workforce crisis in the NHS needs to result in a situation where we no longer see major policies developed without workforce plans behind them. The NAO report noted – as others including The King's Fund have also noted – that some areas of the NHS long-term plan either did not have complete assessments of the staffing required, or identified the staff required without any analysis of whether and how they could be secured. While not unique to the nursing workforce, this issue does particularly affect nurses as they are the largest NHS staff group. As more responsibilities for workforce planning are devolved to local systems, it will be increasingly important to ensure transparency and accountability for how national policies join up with workforce planning.

Second, national roles and responsibilities for the NHS workforce, and above all accountability, have been unclear and fragmented since the reforms of 2013. Great improvements have been made in recent years as NHS England and NHS Improvement, Health Education England and others have worked increasingly closely together. It is important that these bodies continue to develop and embed clear national leadership roles and accountability, especially as the further devolution of responsibilities to local systems – and all the complex design that entails of how local and national responsibilities fit together – could make the picture more complicated still, at least in the short term.

Third, while we await the people plan, the NHS should not take its foot off the accelerator in addressing existing priorities. We particularly highlight the need to continue and increase efforts to

develop workplace cultures in the NHS which promote high-quality care – compassionate, supportive cultures with effective teamworking. Improving workplace cultures, and the leadership practices that shape them, will be of fundamental importance to attract and retain nurses in the NHS and a national framework for progress already exists. But the interim people plan made clear that 'the national bodies have not visibly demonstrated the importance of the [Developing People – Improving Care] framework and its vision' (NHS England and NHS Improvement 2019, pp 14–15). Countless reports – not least the Francis inquiry into Mid-Staffordshire NHS Foundation Trust – have built a compelling case: we already know that developing the right culture and leadership in the NHS should be top of the list for national workforce policy and we need to see more progress with or without a published people plan.

The King's Fund

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