NWF0006

Written evidence submitted by the Royal College of Nursing Evidence

The Royal College of Nursing is the largest professional body and trade union for nursing staff in the world. We represent 450,000 members who are registered nurses, midwives, students, and nursing support workers.

Introduction

1.1. The nursing profession has been at the fore of the response to the pandemic, leading innovation and quality of treatment and care. Nursing staff play an indispensable role in delivering NHS services, and to deliver safe and effective care the service needs. The nursing profession has gone above and beyond during this crisis to support and care for patients, and the public recognises this contribution.

1.2. We also know they feel undervalued after years of working over to cover the huge workforce gap, exemplified through a pandemic where supplies of basic protective equipment were often insufficient to stay safe.

1.3. While the NAO report was published in March, and compiled before the pandemic had hit the UK, our evidence also reflects the experiences of nursing staff during the pandemic. As the NAO's report focuses on the NHS Nursing Workforce in England so does our evidence.

1.4. The NAO report identifies key failures around nursing workforce planning, specifically, due to a lack of clearly defined roles and responsibilities. The report reflects our own findings, that workforce planning has taken place in isolation and in a disjointed fashion which has led to the nursing workforce shortage that the service now faces.

1.5. Before the pandemic, there were approximately 40,000 registered nurse vacancies in the NHS in England alone. The nursing vacancy rate stood at 12% in September 2019.

1.6. Though social care is outside the scope of the report and this inquiry, workforce planning cannot exclude social care. The total number of registered nursing posts in adult social care has decreased by 1,000 in the last year. Since 2012, it has decreased by 10,400, which equates to a 20% drop.

1.7. It is essential that a full assessment is made of the current and future requirements of the nursing workforce in order to properly plan for our future workforce. The NHS People Plan remains delayed and the funding available to ensure its delivery remains opaque. This has, as the NAO identify, been hampered by the diffuse responsibility and accountability for workforce supply.

1.8. As the NAO report highlights, successive efforts at workforce planning have not been successful. It also highlights the discontinuities in planning, such as the NHS budget being settled for the duration of the Parliament but the HEE budget only being settled until 2021 – meaning that planning is likely to be out of step.

Recommendations

We propose that to tackle the workforce shortages and accountability gaps highlighted in the report that:

1. Clear legal duties and accountability for all those who contribute to workforce supply and planning, created through primary legislation.
2. Government and the health service publish a costed and fully funded workforce strategy, with both short- and long-term solutions for supply, recruitment, and

retention for the full range of health and care systems. The aim to should be achieve oversupply in domestic workforce, and a reduced emphasis on international recruitment, over-reliance on which is non sustainable.

3. Introduction of a Chief Nursing Officer role specifically in Government to support the development and delivery of cross-sectoral nursing workforce strategies, recognising that many nursing staff work outside the NHS. During the pandemic, the absence of a Chief Nursing Officer in Government was visible, despite nursing being the largest NHS workforce, and playing a vital role in both leadership and service delivery.
4. To support the domestic nursing supply, the Government should provide students with appropriate financial support on entering and throughout their nursing degrees. To this end the Government should:
    - reimburse tuition fees or forgive current debt for all nursing, midwifery, and allied healthcare students impacted by the removal of the bursary;
    - abolish self-funded tuition fees for all nursing, midwifery, and allied healthcare students starting in 2020/21 and beyond; and
    - introduce universal, living maintenance grants that reflect actual student need.

Nursing Workforce Supply

2.1. The key to tackling the nursing workforce shortage is by substantially increasing domestic supply, by increasing the number of nursing students. The established undergraduate route into nursing must be the primary route and the focus of government strategy, policy and funding as it is the only way to grow the nursing workforce at the necessary scale and pace. The aim should be to achieve oversupply.

2.2. As the NAO notes on page 27, the changes made in 2016 to rely on the higher education marketplace to deliver undergraduate nursing supply have not been effective. This reliance on 'the market' to determine nursing degree places stands in contrast to medical education, where HEE retains its commissioning role, and targets are set for these places.

2.3. As we stated at the time, and as the NAO report confirms, the changes to policy in 2016 had disastrous consequences for the nursing workforce.[1]

2.4. Following the continuing decline in nursing degree applicants, the Government announced earlier this year an annual maintenance grant of between £5,000 and £8,000 per student from September 2020.

2.5. On 9th July, UCAS released data for nursing student applications across UK universities. The increase in applications of 16% this year is welcome. However, we are still behind the application numbers when full financial support was in place in 2016.

2.6. In 2019, the number of students accepted onto a nursing degree was still 8% down on the numbers since 2016 - the final year of the bursary, which covered the cost of nurse tuition fees and living costs.[2] The supply pipeline is therefore a substantial distance away from sufficient, given the intention of the reform was to increase this numbers.

2.7. A rise of nursing application is encouraging however with higher investment, the numbers of nursing students would increase at a much faster rate – starting to close the gap between available workforce and patient need. Currently, even with the new living grants, nursing students must graduate with at least £27,750 of debt to pay off. This will not incentivise greater numbers - including from diverse backgrounds - to choose nursing.

[1] https://www.rcn.org.uk/news-and-events/press-releases/rcn-launches-fund-our-future-campaign

[2] https://www.rcn.org.uk/news-and-events/press-releases/ucas-results

2.8. There are a number of options available to government to cover the costs of nursing education, to incentivise more people to enter the profession. We have published two potential funding options:

2.9. A means-tested maintenance grants plus non-means-tested tuition fee grants would bring a net benefit to the exchequer of at least £132 million by reducing the reliance on bank and agency staff in publicly funded services.

2.10. Moving to forgivable tuition fee loans plus maintenance grants, written off in chunks at 3, 7 and 10 years after a student graduates would incentivise retention in public services, and secure a net extra benefit of £172 million, achieved through a reduced reliance on bank and agency staff in publicly funded services.[3]

2.11. As it takes three years to educate a nurse, the Government should act quickly and decisively to ensure the long-term supply of nurses, by: reimbursing tuition fees or forgive current debt for all nursing, midwifery, and allied healthcare students impacted by the removal of the bursary; abolishing self-funded tuition fees for all nursing, midwifery, and allied healthcare students starting in 2020/21 and beyond (our funding options set this at £10,000); and introducing universal, living maintenance grants that reflect actual student need.

2.12. While the NAO looks at other routes into nursing such as the Nursing Associate conversion and Nursing Apprenticeships (both four years), these must be seen as secondary routes to increasing domestic supply, due to their relative size, and focus on these roles must not come at the expense of significantly expanding the number s of students taking nursing degrees.

2.13. In the short-term, international recruitment has been a lever used by Government to address the shortages in the nursing workforce. However, not only is over-reliance on an international workforce unsustainable, but the COVID-19 pandemic is likely to hamper international recruitment if national borders remain closed and countries across the world experience heightened demand for nurses. It is essential that international recruitment during this context in particular is held to rigorous ethical standards, and with full transparency regarding each government to government arrangement.

2.14. On 9th July, NMC data on registrant leavers and joiners was released – delayed from March. The data highlights that there is an increasing overreliance on internationally educated nurses to fill the vacancy gaps. There was a 2.6% growth in the size of the nursing register, the largest rises came in professionals trained outside the EEA. Of these professionals, 33,297 (41.9%) were trained in the Philippines; while the numbers from the EEA fell by 5%.

2.15. The Government has a responsibility to ensure that it is staffing our public services to enable safe and effective care, and therefore we expect increased investment in domestic nursing workforce supply.

Staffing Levels

3.1. There is significant evidence that the level of staffing, and in particular the number of registered nurses in a hospital have an impact on patient outcomes. A growing evidence base shows the impact of registered nurse staffing levels on the quality of patient care and outcomes.

3.2. Research suggests a correlation between nursing workforce staffing levels and clinical patient outcomes. A study on staffing for safe and effective care in an acute NHS Trust in England found 40 correlations between safety factors, physiological data and staffing factors.

[3] The full details are available in our submission to the Treasury: https://www.rcn.org.uk/news-and-events/news/uk-rcn-submits-pre-budget-asks-for-nursing-270220

3.3. The National Nursing Research unit in a study across nine countries (including England) reported that an increase in a registered nurse workload by one patient increased the likelihood of an inpatient (undergoing common general surgery) dying within 30 days of admission by 7%. Further, every 10% increase in the number of degree educated nurses was associated with a 7% decrease in the likelihood of patient death.[4]

3.4. As the NAO report notes, "the Care Quality Commission State of Care report raised general concerns about the impact of low staffing levels affecting the quality of patient care, as well as increasing pressure on staff and further contributing to staff shortages."

3.5. The NAO report cites evidence that productivity has grown much faster than the nursing workforce, and this is reflected in our surveys which found that three-quarters (79%) of nursing staff are working excess hours at least once a week and well over half (57%) state that these hours are usually unpaid. 66% say they are under too much pressure and 67% are too busy to provide the level of care they would like.[5] Recent NMC data also showed that, after retirement, too much pressure was cited as the single largest reason for leaving the profession.[6] It is therefore clear that productivity within the nursing profession has been pushed to its limit, if not beyond, presenting a risk of burn out.

3.6. For these reasons, securing the appropriate workforce expansion now and in the future not only enables to better patient outcomes, but also reduces the levels of workforce stress, which themselves have a negative impact on staff morale and retention.

Retention

4.1. The NAO notes that the leavers rate has also increased in the NHS since 2012, rising from 9% in 2012/3 to 10% in 2017/8. Although recent data from the NMC has shown an increase in nursing staff, there is more to do before the Government's ambition of 50,000 more nurses will be achieved. Indeed, the NMC data shows that over a third of the register is aged over 50, and so there will be significant workforce challenges in the next decade unless domestic supply is increased.[7]

4.2. Though the NAO report looked at data from NHS Digital on nurses' resignations, this data did not look at those who were leaving the profession, but those who were leaving their current employer, and so the primary reasons for leaving given included relocation (26%), though 21% cite work/life balance as a primary reason.

4.3. Our recent survey, released on 17th July, of over 42,000 nurses, looking at staff experiences of the pandemic found 36% of respondents were considering leaving the profession in the next year, compared with 28% before the pandemic hit.

4.4. A third of staff said they felt less valued by Government during the pandemic than before, and a quarter felt less valued by senior management in their organisation.

4.5. When asked what was causing them to consider leaving the profession, members told us it was levels of pay (64%); Low staffing levels (45%); The way nursing staff had been treated during the pandemic (45%); A lack of management support (44%)

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[4] Our 2019 report *Staffing for Safe and Effective Care: RCN Member Campaigning in the UK* sets out the evidence base in more detail: https://www.rcn.org.uk/professional-development/publications/pub-007674#detailTab

[5] https://www.rcn.org.uk/professional-development/publications/pub-007927

[6] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-register/march-2020/nmc-register-march-2020.pdf

[7] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-register/march-2020/nmc-register-march-2020.pdf

4.6. Retention of the staff who have come through the COVID-19 pandemic will involve more than just pay, it will involve providing access to specialist mental health support for nursing staff, who have worked through an intensely stressful and traumatic period, as well as carrying out risk assessments for staff, and ensuring that staff who may be exhausted are able to take rest breaks and annual leave.

4.7. Nursing staff had nearly a decade of their pay being capped at 1%. Nursing has for a long time been devalued and low paid, despite being a highly skilled degree profession. Although the Government quote 'In the past three years, nurses have seen their starting salaries increase by more than 12%' (House of Commons Petitions debate on reward and pay in June 2020), this relates to the pay of some nurses but does not relate to the experience of the majority of our members.

4.8. With the other health unions, we are calling on the Government to begin an honest and immediate conversation on nursing pay. Three quarters of staff told us that improved pay would make them feel more valued. Nearly half of staff identified improved pay as the single biggest factor that would make them feel more valued.

Workforce accountability

5.1. The lack of effective workforce planning and accountability leads to financial inefficiencies across the health service. As the NAO report highlights, the NHS currently spends £2.4bn on agency staff and £3.4bn on bank staff to fill gaps in the workforce, so effective workforce planning across the system is essential for the effective use of the NHS budget.

5.2. The Long Term Plan needs the right number of health and care staff in the right place at the right time. It makes sense to clarify accountability for workforce alongside accountabilities for other aspects of local and national service design and planning.

5.3. There is a clear opportunity for the Government to address these issues, substantially, in full, and to future-proof our health and care system once and for all. Leaders within the NHS have proposed an NHS Integrated Care Bill.

5.4. Accountability for workforce supply, recruitment, retention and remuneration – within Government, and throughout health and care agencies nationally, and organisations locally – should be core to any update to health and care legislation. Law alone is not the answer, but as with all other aspects of Government and system roles in service planning, and quality, it is a fundamental part of it. Implementation can be phased, when fully understood and planned. It is essential that legislation and strategy do not work to address workforce issues in the NHS in isolation, since the pipeline of nursing supply is the same for the entirety of the health and care system and services.

July 2020