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This written evidence covers five areas:

1. Issues with the existing system – burnout and progression
2. The lack of a national nursing workforce plan and the disconnect between Higher Education and the NHS
3. The recruitment of nursing lecturers
4. International recruitment of nurses
5. The impact of covid-19 on the workforce

1. Issues with the existing system – burnout and progression

1.1 Many nurses are suffering from burnout 15-20 years into their career, with an increased number of nurses leaving the profession in their late thirties to mid-forties. This has resulted in an ageing workforce, and an ageing workforce leadership.

1.2 There is no national career pathway through nursing, with no clear way to move across and progress through the NHS. Good nurses are promoted to leadership positions but there is no preparation for the skills one might need in that new professional context. Often, the only way of acquiring those skills is to disengage from the system, gain the experience elsewhere, and then re-engage later.

1.3 Rather than NHS trusts working as an integrated system, at times trusts act more like private sector corporations that compete for talented staff, “poaching” them from other trusts.

1.4 It is vital that planners have a “start-to-finish” approach to the workforce, rather than simply focusing on recruitment.

2. The lack of a national workforce plan and the disconnect between Higher Education and the NHS

2.1 All workforce plans should look ahead at least 3-5 years in order to account for the time it takes to train new nurses.

2.2 To qualify as a nurse rightly requires 2300 hours of practice. It is therefore only possible to increase the number of nursing students if there are a corresponding number of practice placements available.

2.3 However, there is a disconnect between Higher Education (HE) and the National Health Service which makes workforce planning difficult. There is no structural link between HE and local authorities or NHS trusts and therefore no way of efficiently coordinating the supply of new nurses in a way that is sensitive to national or even regional demand.

2.4 Nursing used to have a similar commissioning model to medicine. Reinstating this model would be a good basis for beginning to integrate properly the HE and NHS components of the system.

2.5 Chief nurses have said that they need to have access to the workforce earlier, which was part of the rationale for introducing apprenticeships. However, there are tensions between the apprenticeship model and HE. Universities are not like training centres; they need a viable cohort who all start at the same time. This clashes with the apprenticeship model, which requires greater flexibility. At Manchester Metropolitan University, the apprenticeship model is only used in higher nursing qualifications. Trusts must also pay an apprenticeship levy, which militates against an apprenticeship’s cost-effectiveness for the trust.

3. The recruitment of new nursing lecturers

3.1 A lesser commented upon issue is the problem in recruiting staff to train new nurses. Difficulties arise as lecturer and senior lecturer pay in HE is often less than in professional practice, which disincentivises recruitment.

3.2 Staff shortages also mean that NHS trusts do not want to release nursing staff to teach. To pay for backfill can also be more expensive, which further disincentivises trusts.

4. The international recruitment of nurses

4.1 The nursing workforce shortage is not restricted to the UK but is a global problem. This means that the labour market is a sellers' market.

4.2 UK nurses' pay is highly uncompetitive. For example, average pay in Australia is double that in the UK, and in the US it is on average approximately one third more. This militates against the international recruitment of nurses.

4.3 We should therefore be mindful of the risk of a potential "brain drain", with UK trained nurses travelling to take up positions with better pay and conditions abroad.

5. The impact of covid-19 on the workforce and recruitment

5.1 The pandemic has exposed existing weaknesses in the system.

5.2 The ageing workforce meant that a higher number of nurses suffer from chronic conditions. More nurses were consequently at risk to covid-19 which correspondingly meant there were more nurses who were required to shield, creating extra staffing pressures during the peak of the pandemic.

5.3 The effects of covid-19 on HE are also likely to affect training pipelines. Unlike other degree programmes, nursing students are required to learn practical clinical skills which requires a physical classroom setting. Coronavirus has placed restriction on the number of students that can safely attend a class. As a result, it is possible that students will be unable to complete their training in three years, which will affect the future supply of nurses.

5.4 Covid-19 has also illuminated the disconnect between HE and the NHS. At the beginning of the crisis, second and third year nursing students were taken off their studies and recruited to address staffing gaps in the NHS on the understanding that these paid placements would contribute to the practice hours required to qualify. However, the hospital staffing demands of covid-19 were over-estimated. To take Manchester Metropolitan University as one example, this meant that up to one third of students were not deployed. It is entirely possible that the cost of this disruption will be further delays in the supply of newly qualified nurses, as universities struggle to find placements to make up the hours, and to teach the theoretical material students missed due to the suspension of their studies.

5.5 To avoid this issue, there should have been a phased recruitment, starting with a recall of experienced nurses, followed by third year students, and then the second years.

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