From Boom to Bust?

The UK Nursing Labour Market Review 2005/6

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Summary

- Fiscal uncertainty and NHS funding difficulties are contributing to NHS nurse workforce planning requirements being given insufficient consideration in current policy discussion

- The impact of NHS funding constraints should not only be measured in terms of actual redundancies. Other measures, such as freezing vacancies, are bound to have a negative impact on patient care

- In the years up to 2005 there had been marked, but variable growth in NHS nurse numbers across the four UK countries; more recent surveys suggest that there are likely to be significant reductions in intakes to pre-reg nurse education this year

- International recruitment has made a central contribution to meeting NHS nurse staffing growth targets in England; however international inflow is now reducing markedly as a result of NHS funding difficulties and reduced availability of posts for newly qualified UK nurses

- Outflow of nurses from the UK appears to have remained stable in terms of overall numbers, up to March this year. Australia, New Zealand and the USA are the main destinations

- The objective of prioritising NHS primary care developments may be compromised and constrained by inadequate numbers of community trained NHS nurses, and by the impact of ageing on the community nursing workforce

- Applications to pre-reg nurse education have continued to increase, up to early 2006, but rates of growth have varied by country, region and branch

- There is continued disagreement about the accuracy of measures of attrition from pre-reg education, but there appears to be marked variation by educational institution and by branch

- Recent survey findings suggest a much lower proportion of newly qualified nurses is finding employment than was the case twelve months ago

- There are about 640,000 registered nurses based in the UK in 2005, and 473,000 were working in the NHS

- The impact of ageing on the level of participation in employment of nurses has not been fully assessed but is likely to be pronounced, notably in community nursing

1.Introduction

"The work force projections that the Department of Health undertakes are all based on local projections of need developed by individual hospitals and other parts of the NHS. It is already clear that when the assessments of requirements for training places were made some years ago, several hospitals overestimated their requirements. A minority of hospitals were, even at that point, overspending their budgets at the expense of other parts of the NHS, yet also taking on new staff and commissioning new training places—and now they cannot find jobs for all the nurses who have been trained. That situation is extremely unsatisfactory and unfair to the staff involved".

Patricia Hewitt, Secretary of State for Health, July 18th 2006. (Hansard)

"…a key objective must be much more effective alignment of workforce and financial planning, which has been very poor. We need to achieve a clearer correlation between delivering financial performance targets and investment in human resources" .

Evidence submitted by the five London Strategic Health Authorities to the Health Committee, 2006

This report is the annual review of the UK nursing labour market, commissioned by the Royal College of Nursing. Twelve months ago, our report for 2004/5 concluded that the nursing labour market was entering a period of uncertainty, with signs of redundancies and recruitment freezes emerging in some parts of the NHS, particularly in England. We highlighted the concern that short term and unplanned responses to financial difficulties had the potential to undermine workforce planning and store up problems for future years. These concerns have become much more pronounced in recent months.

Last year we noted that in the early 1990's "Fragmented planning, poor data, inadequate national oversight and a lack of appreciation of the dynamics of the UK nurse labour market led to several years of underinvestment in nurse education, against a backdrop of general NHS underfunding. The end result was that the numbers of nurses being trained was drastically reduced, and within a few years vacancies were rising, NHS nursing shortages had became a major obstacle for NHS reform…."(Buchan and Seccombe, 2005)

After a period of unprecedented growth in NHS funding and in the NHS nursing workforce, the concern now is that we are entering a time of greater fiscal uncertainty, when workforce planning projections and requirements are ignored or downplayed, with a rapid shift from financial boom to bust. The situation was summarised recently by NHS Employers as:

"A number of changes are currently taking place in the NHS which are having a significant impact on its workforce. More care for patients is being provided in services outside of hospitals, new staff roles and new technology are constantly emerging, the structure of PCTs and SHAs is undergoing change and there are more new non-NHS providers of healthcare. All these factors, combined with the fact that some trusts are facing financial difficulties have a direct effect on how staff work…….. Employers and staff need to be supported through these changes and helped to develop new opportunities for working in the community, contracts that are more flexible and training programmes that prepare people to work in a range of settings…." **(NHS Employers, 2006)**[1]

The current organisational changes in the NHS in England , with reductions in the numbers of PCTs and Strategic Health Authorities, and the de-concentration of some workforce planning and policy responsibilities, such as international recruitment and large scale workforce change, to NHS Employers means that the NHS workforce planning process in England is once again confused, with multiple stakeholders and uncertainties about future focus, responsibilities and structures. There is a danger of a fragmented system emerging, with overlap and gaps, a lack of clear lines of responsibility; an absence of effective integration and oversight at national level, and, inadequate capacity at local and regional level. For example, it is not always clear who at local level will have the capacity and the responsibility for implementing the recommendations from the Workforce Review Team, highlighted in this report. This concern has been highlighted elsewhere:

"Q40 Jim Dowd: What about the disadvantages of this reorganisation?:

Dr Curson [SHA Dean & Director of Workforce Review Team] Certainly in terms of the SHA reorganisation, there is a concern that there are very few workforce planning skills amongst SHAs and in the NHS generally and that is one of the reasons National Workforce Projects have actually set up the first training programme for workforce planners. There is a very real concern that these skills might be lost as people apply for jobs, even outside the NHS, while they are waiting to see whether they do have a future in the new health authorities"[2].

It is also evident that there remain weaknesses in the available data which can undermine effective nursing workforce policy and planning. Many of these weaknesses are well known but have not, as yet, been effectively addressed. In the labour market review published last year, we set out our analysis of the main information gaps that were undermining a complete policy analysis of the dynamics of the UK nursing labour market, and were impairing effective workforce planning. All these weaknesses remain (see Annex 1), compounded by the current financial difficulties in parts of the NHS, and the uncertainties created by organisational change.

This report is in two further Chapters. **Chapter 2** highlights the critical nursing workforce aspects of the recent NHS funding difficulties, and other key issues such as the ageing of the nursing workforce as they impact on current and future workforce planning. Because of the time lag in the collection and publication of official NHS data, this section cannot rely on extensive data, as much of the recent changes are not yet evident in published reports, many of which use information from 2005. **Chapter 3** of the report provides an overview of the profile of the nursing workforce across the four UK countries, drawing from official data sources. As such, it presents a detailed overview of the profile only up to late 2005, pre-dating the more recent events that have impacted negatively on the NHS nursing workforce, particularly in England.

2. From Boom to Bust?

"SHAs are looking for savings in those areas with the greatest return, e.g in nursing…"
NHS Workforce Review Team, June 2006[3]

This report is published against a nursing labour market backdrop very different to that existing twelve months ago. Financial difficulties and deficits in parts of the NHS, most notably in England, have led, in places, to recruitment freezes and redundancies. There are also reports of reductions in funding for future training of nurses[4], and of newly qualified nurses experiencing difficulties in finding nursing jobs[5],[6]. In our previous report[7], we highlighted that UK nursing labour market indicators were pointing to a more uncertain and challenging future than had been the case in the earlier part of the decade. It is apparent that these labour market challenges have become much more pronounced in recent months.

In January this year, the NHS Confederation, which represents nearly all NHS organisations, reported that those NHS trusts facing financial difficulties were taking a variety of "short term action":

- 90 per cent are reducing agency staff costs
- 85 per cent have put a freeze on new expenditure
- 82 per cent have imposed a vacancy freeze
- 78 per cent have seen staff reductions
- 52 per cent have temporarily closed wards
- 48 per cent are rescheduling work
- 38 per cent have cancelled services or restricted eligibility for services
- 28 per cent have frozen partnership or other contractual arrangements

NHS Confederation, 2006[8]

A survey of 4000 nurse managers, conducted in March 2006 for the RCN, reported that 45% of hospital based managers identified redundancies or reduction in nursing posts where they worked, in the last twelve months (49% in England, 28% in Northern Ireland, 32% in

Scotland and 22% in Wales). The most frequently cited form of staffing reduction was recruitment freeze (reported by 50%), followed by posts cut or establishment reduced[9].

It is important to note that there is a variable pattern of change occurring, in relation to recruitment and retention of NHS nursing staff. In an interim report based on the responses to a survey carried out in March 2006 for the Review Body[10] , 33% of NHS employers responding to the survey reported that recruitment of nursing staff was "less difficult" over the last 15 months; 53% reported "about the same", and 10% reported "more difficult". Two thirds of NHS employers (65%) also reported that retention of nursing staff was "about the same" as 15 months ago; with one in five (20%) reporting that retention was "less difficult". Provisional findings from the parallel survey of joining and leaving rates in the NHS in England and Wales, from March this year, indicate that the matched sample wastage rate (ie nursing staff leaving the NHS) was 8.5% in England (down from 8.9% in the previous year), and 6.8% in Wales (note this data covers all nursing staff including unqualified)[11]. The utility of this survey is limited by the high percentage of "don't know" answers from NHS employers relating to the source or destination of nurse joiners and leavers.

There has been debate and disagreement about the actual impact of financial constraints on staffing levels. The RCN have reported 18,000 NHS posts "under threat", approximately 1,500 of which are nursing posts. NHS Employers have countered by arguing that "Where trusts are making reductions in their workforce they are typically doing so by freezing vacancies or reducing the use of agency and temporary staff, as well as redeploying staff in different ways……Compulsory redundancies are a last resort and NHS employers are doing all they can not to lose valuable staff or to compromise patient care"[12]. One of the main differences in opinion centres around the distinction between an individual being made redundant, and a post being "frozen" or unfilled when an individual leaves it.

A focus only on "official" data does not provide an up to date picture of the impact of recent changes. At the time of writing, the most recent NHS staffing data is from September 2005, which pre-dates much of the action to tackle financial problems. What these data do illustrate is the impact of financial growth in the NHS until that time, driving up staffing numbers. This had been achieved by a range of policy initiatives in the four UK countries, designed to increase the numbers of new nurses being trained; to improve retention of those already in nursing; to attract back those who have left; and to undertake active international recruitment. Of the three "home based" initiatives, it was the increase in training that had the largest numerical impact in recent years[13].

Using the most recently published comparable workforce data from the four UK countries it is evident that significant but variable levels of overall nurse staffing growth have been achieved over the period 1997-2005 (Table 1; some caution is required in interpreting data as definitions vary in the four countries, and across time).

Table 1: Whole time equivalent and per cent change in the NHS Qualified Nursing and Midwifery Workforce, 1997 to 2005, four UK Countries (September).

	1997	**2005**	**%Change 1997 - 2004**
England	246,011	307,744	**25%**
Scotland	35,245	39,837	**13 %**
Wales	17,228	20,698	**20%**
Northern Ireland	11,508	13,345	**16%**

Sources: England: non medical staff census, The Information Centre, NHS. Northern Ireland – DHSSPSNI; data is for March; Scotland data - ISD Workforce Statistics; Wales –SB25/06;. Note: per cent Figures are rounded. NOTE: Data for England includes bank nurses; data for other three countries does not.

The rate of growth in nurse staffing achieved in the four UK countries since 1997 has been variable, with England reporting notably higher growth (partly related to inclusion of bank nurses), and Scotland reporting the lowest rate of growth.

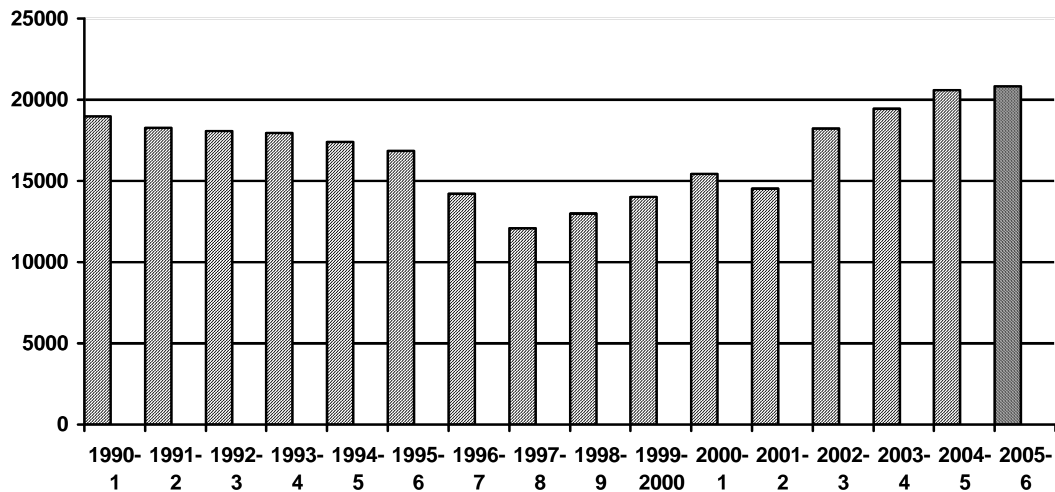
“New” UK Supply of Nurses 1997-2005…….and beyond?

In recent years there has been significant annual growth in the numbers of new nurses entering the UK register from pre-registration education in the UK, following on from a period of substantial decline in the previous decade. The current concern is that there may now be a marked decline in intakes in 2006/7 because of funding constraints, which in later years could lead to a reduction in new UK educated nurse registrants.

Growth in the period between the late 1990’s and 2005 reflects an increase in admissions to pre-registration nurse education, supported by increased government funding, and the impact of national advertising campaigns. In England, in 2004/5 £5.8 million was spent by the NHS in recruitment and advertising campaigns[14].

The pattern of decline and growth is shown in Figure 1. In 1990/91 there were 18,980 “new” nurses entering the UK register from education and training in the UK. The annual number of entrants fell year on year to a low of just over 12,000 in 1997/8. This decline was a direct result of the significant reductions in the number of student places that were funded in UK nurse education in the first half of the decade.

Figure 1: Number of new entrants to the UK nursing register from UK sources, 1990/1 to 2005/6 (estimate)



Source: NMC/UKCC. [Data for 2005/6 is estimated, based on first nine months data]

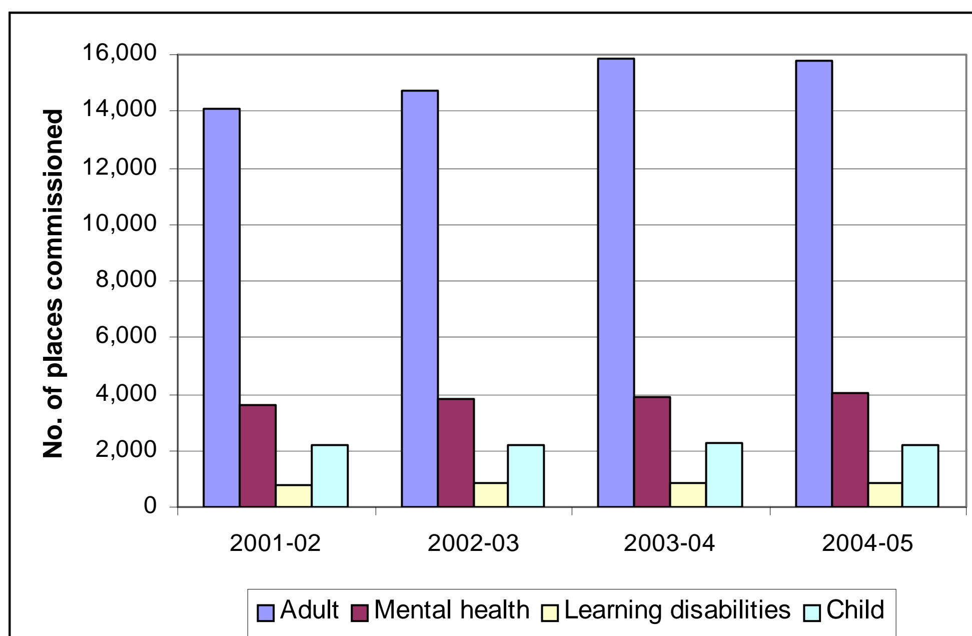
There was then a significant upward trend between 1997/8 and 2005/6; the new intake from UK education exceeded 20,000 in 2004/5, and provisional data for 2005/6 suggest that this growth has continued. It should be noted however that financial pressures in the NHS in England are likely to reduce significantly the number of training places commissioned in 2006/07; data is not yet available to assess the actual size of the likely decline. In Scotland a 10% cut to intakes was announced[15].

There has, until 2005/6, been significant growth in the number of student nurse places being funded by the NHS. In England, the NHS Plan pledged that, by 2004, there would be 5,500 more students entering training for a first qualification to become a nurse or midwife than in 1999. Between 1999–2000 and 2003-04 there was an overall increase of 5,577 in the number of places commissioned[16], meeting the target set. More recent figures[17] based on returns from SHA quarterly monitoring forms are provided by branch, for pre-registration nursing only, in Figure 2.

These data show:

- first, that there has been an overall increase of more than 2,750 training places since 2001-02 (20,610) with 23,377 in 2004-05
- second, that the increase in commissioned places continued through 2004-05, albeit at a slower rate (2.5% compared with 6% in 2003-04)
- third, there were significantly different rates of growth between the four branches, with mental health (13%) and adult (12%) increasing proportionately more than the learning disabilities (6%) and child (3%) branches.

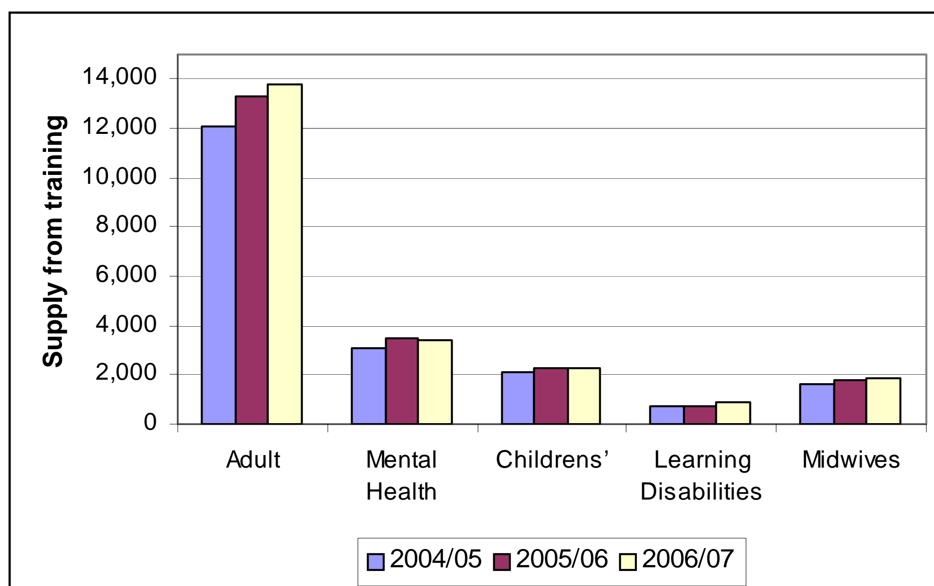
Figure 2 Pre-registration nursing training commissions 2001-02 to 2004-05 (England)



Source: House of Commons, Hansard, Written Answers, 5 October 2005

Allowing for students who fail to complete their course or delay completion, intakes at this level are expected to supply, on average, 20,000 newly qualified nurses and midwives each year. In 2004, the NHS Workforce Review Team estimated that the supply of newly qualified nurses and midwives in England would rise to 21,300 in 2005/06 and 21,900 in 2006/07 (Figure 3).

Figure 3 Forecast supply from commissioning in academic years 2004/05, 2005/06 and 2006/07, by branch (England)



Source: WRT Survey of SHAs May 2004
Note: estimated on the basis of returns from 16 SHAs

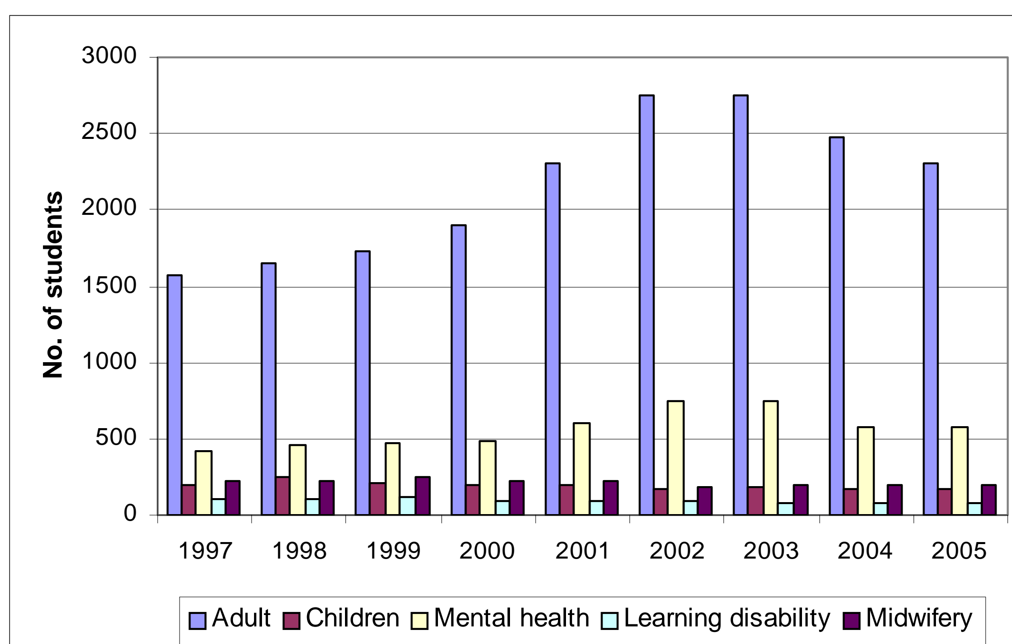
Information on the number of training places anticipated in future years is not available, though planning assumptions made in 2004 were for a 4% increase in commissions each year from 2006.[18] In practice, the rate of increase had already fallen below this (to 2.5% in 2004-05) when this assumption was made.

More recently, analysis of a survey[19] of member universities in England by the Council of Deans and Heads of UK University Faculties for Nursing and Health Professions reported an overall average reduction of 10% in pre-registration student numbers being commissioned for 2006-07 with some institutions forecasting a 30% cut and in one case 40%.[1] The Council found that the largest reductions were in those SHAs with the largest projected deficits for 2005-06.

[1] The Council's survey also reported substantial reductions in commissioning for post-registration and continuing professional development at many universities.

In Scotland, recent years have seen a marked increase in the intakes recommended by the Student Nurse Intake Planning (SNIP) exercise over those of the late 1990s (Figure 4). However, planned intakes in 2005/06 (SNIP 2004) and 2006/07 (SNIP 2005) reverse this trend, with planned reductions of 11.5% and 5% respectively. SNIP 2005[20] shows a total planned intake for 2006/07 of 3,325 (175, or 5%, lower than 2005/06). No changes in intakes for learning disability, mental health or midwifery were planned, with a small (3%) increase for the children's branch but a 7% drop for adult. The latter was initially expected to drop from 2,480 to 2,100 but this was subsequently revised upwards to 2,300.

Figure 4: Intake recommendations for pre-registration nursing and midwifery in Scotland, SNIP 1997 to 2005



Source: SNIP

In Northern Ireland, the annual number of pre-registration nurse training places was increased from 580 to 680 in 2001 and to 750 in 2002.[21]

It is clear that the significant increase in funding to commission pre-registration nurse education places in the UK has been the main contributor to staffing growth up to 2005, at around 15-20,000 per annum in recent years, and that there will be continued growth over

the next two years in numbers of nurses coming out of pre-registration education as a result of the growth in intakes in recent years. The most recent information from the Council of Deans suggests a rapid decline in commission of places in some parts of the NHS in England, which could lead to reductions in the number of student nurses qualifying and entering the labour market at the end of the decade.

The quick fix of international recruitment

"Some initiatives have served their purpose and will not have a big impact in the next five years. International recruitment was not intended to be a long-term strategy and since 2005 there has been a steady decrease in the volume of international recruitment in all sectors. Increasingly as the year-on-year increases in training emerge, the health service will be more self-reliant on UK trained doctors, nurses and other healthcare professionals"
Department of Health Written Evidence to Health Committee, 2006, para2.8

"International recruitment has been an important part of the strategy to tackle key skills gaps and "hard-to-fill" jobs over the last five years"
Department of Health Written Evidence to Health Committee, 2006, para 3.16

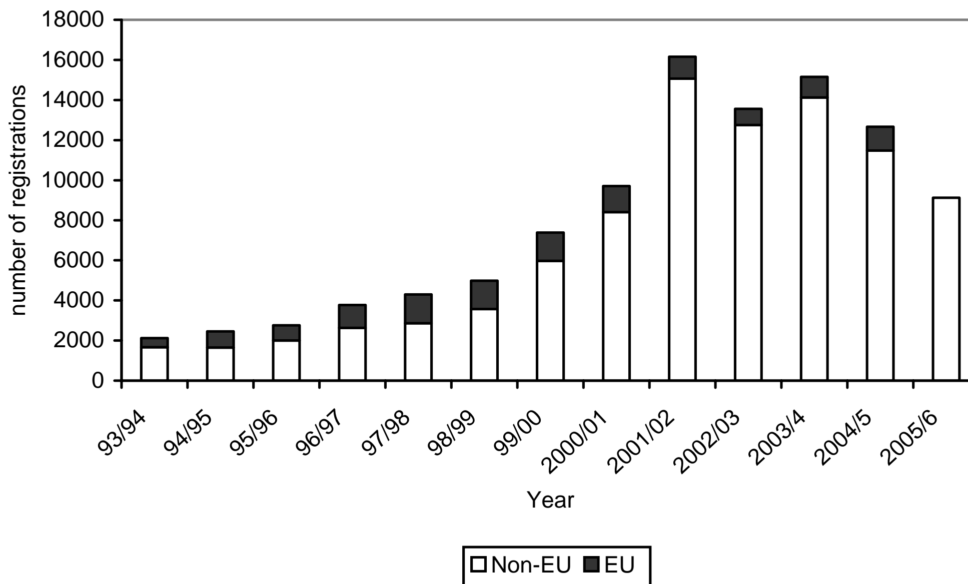
The other source of "new" nurse recruits is active recruitment from other countries. International recruitment is attractive to policy makers because it enables rapid recruitment without the expense and lead in time that commissioning more home based training places requires. In the period between the late 1990's and middle of this decade, the UK, particularly England, was actively recruiting nurses from a range of countries. A network of NHS international recruitment co-ordinators facilitated overseas recruitment by NHS organisations, the NHS Purchasing and Supply Agency issued guidance on procurement of international healthcare professionals[22], and NHS international recruitment activity was covered by a Code of Practice[23].

In 2006 band 5 and 6 nursing posts (the main entry clinical grades in the NHS) were removed from the Home Office "shortage occupation" list. This means that UK employers cannot recruit these types of nurses unless they have actively tried first to recruit within the UK or elsewhere in the European Union (However, some specialist nursing posts remain on the "shortage" list)[24]. In effect, this means a rapid and significant reduction in UK international

recruitment activity outside the EU. The expansion of the EU may mean that more nurses enter the UK from the accession states; the available data from the NMC on EU nurses is not up to date and makes it difficult to assess the significance of EU countries in recent months.

The level of UK reliance on international nurses can be assessed with data from the Nursing and Midwifery Council (NMC)[2]. The key indicator is the level of initial admissions to the NMC Register of nurses and midwives originally trained and registered outside the UK.

Figure 5 : Admissions to the UK nursing register from EU countries and other (non EU) countries 1993/94 - 2005/6 (estimate)



Source: NMC/UKCC [Note: 2005/6 non- EU estimate is based on data from first nine months of the year; EU data not yet available]

Rapid growth in the annual numbers of entrants to the UK register from overseas in the late 1990's and earlier years of this decade is highlighted in Figure 5. Since April 1997 there has been an aggregate total of more than 90,000 overseas admissions to the UK register. However, there has been a marked reduction in overseas registrants in recent years.

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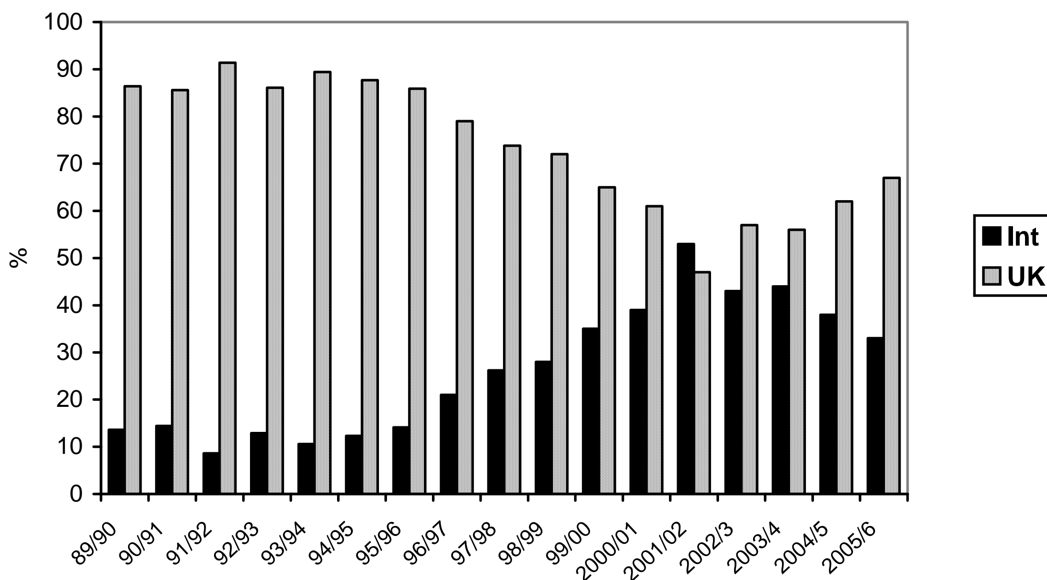
[2] There are limitations in using NMC data to monitor the inflow of nurses to the UK, because it registers intent to work in the UK, rather than the actuality of working. Overseas nurses may be registered, but not move to the UK, or they may move to the UK but not take up employment in nursing.

The importance of overseas countries as a source of new nurses for the UK is highlighted in Figure 6, which shows the relative contribution of UK and of overseas sources to "new" nurse registrations since 1989/90. In the early 1990's, overseas countries were the source of about one in ten nurses entering the UK register. The overseas contribution rose rapidly in the late 1990's, both in terms of numbers and as a percentage of total new entrants. In the most recent years there has been some reversal of that trend, because of the larger numbers coming onto the register from UK sources, as highlighted in Figure 5.

Figure 6: International and UK sources as a % of total new admissions to the UK nursing register, 1989/90 - 2005/2006 (estimate) (Initial Registrations)



Source: UKCC/NMC data; (2005/6 estimate is based on data available for first nine months of the year)

The recent reduction in the number of international nurses entering on the UK register is mainly a result of declining demand in the UK, but is also partly due to the effect of the new NMC requirements. The new Overseas Nurses Programme (ONP), and new English language tests, introduced by the NMC from September 2005 had already begun to limit the number

of successful applications from some countries[25]. The NMC has also announced that the English language test pass score for overseas nurses applying for UK registration will be raised to an overall pass of 7.0 in the IELTS, from February 2007, which will act as a further constraint on any potential inflow [26]. EU nurses are not required to have passed the IELTS test.

As noted earlier, one of the reasons that active international recruitment has been so attractive to policy makers in the UK is that it offers a "quick fix". The nurses have been trained elsewhere, at someone else's expense, and can be recruited and working in the UK within a few months, not the four years it would take to commission and train a UK educated nurse. Equally, if and when funded demand for nurses in the UK falters or reduces, the numbers of international recruits can also be reduced, virtually overnight. This is now happening in the UK. In addition, international nurses already working in the UK may find that their work permits are not renewed and they will have to leave the country

"The numbers coming out of domestic training, because we have been investing in that year on year, are increasing. We are becoming less and less reliant year on year on staff from overseas and many of them came over here with fixed-term contracts of two to three years which are now not being renewed for that very reason".
Andrew Foster, previous HR Director, NHS, England, May 2006[27]

"The advantage of the managed migration policy is that where shortages arise – and there are shortages in specialist jobs in the NHS – they can be included in the shortage category so that employers can obtain work permits for nurses from abroad. This is a flexible system that can respond to our own labour market."
Secretary of State for Health, Hansard, July 18th 2006[28]

Outflow of Nurses from the UK

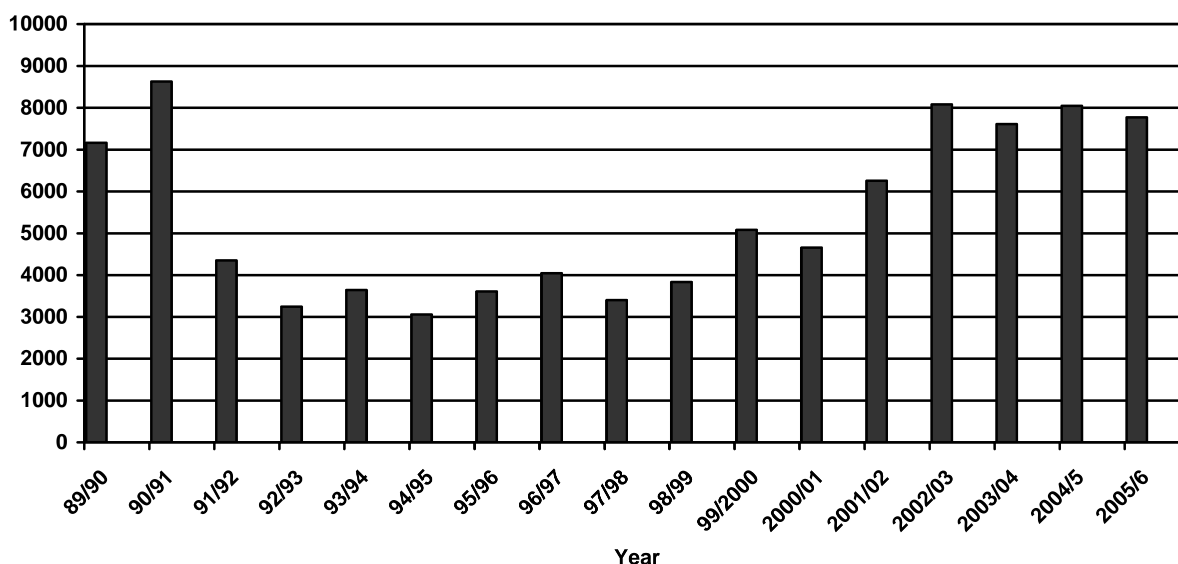
International flow of nurses is two way. Recent UK nursing press stories have suggested that overseas recruiters are deliberately targeting areas of the UK where NHS job cuts and recruitment freezes have been announced[29]. Like the UK, the US, Canada and Australia have all highlighted their ageing nurse populations, which, over the decade, could exacerbate current nursing shortages. The US has quantified its nursing recruitment need as being in excess of 1 million registered nurses between now and 2012 (including 623,000 to fill newly

created jobs)[30]. The Canadian situation has been quantified as a shortfall of around 78,000 nurses by 2011[31]. In the USA there is also reportedly an increased effort to attract more foreign nurses by increasing the availability of visas, as a result of lobbying by the American Hospital Association[32].

Some estimate of the outflow of nurses from the UK can be determined using data held by the NMC on verifications reported to other countries. Whenever a UK registered nurse applies for registration in another country, that country's registration body should contact the NMC for verification of the nurse's details[3].

Overall trends in outflow are shown in Fig 7. The number of verifications issued declined in the first half of the last decade, there was then a rising trend , followed by a "flat line" period in the last four years. Australia, New Zealand and the USA accounted for three quarters of all verifications in 2005/6.

Fig 7: Annual no. of verifications issued by NMC/ UKCC, 1989/90 - 2005/2006



Source: NMC/UKCC

[3] The NMC data indicates an intention to nurse in other countries, it does not necessarily record an actual geographical move. There will also be some double counting when a nurse applies to move to more than one country, and some of the outflow will be of foreign nationals who, having undertaken pre- or post-registration nurse education in the UK, return home.

The UK has tended to receive nurses from English speaking developing countries in the "new" Commonwealth in Asia and Africa (plus the Philippines), whilst "losing" nurses to English speaking developed countries in the old Commonwealth (plus Ireland and the USA).

The changes in the dynamics in the UK nursing labour market have been rapid, and much of the available data predates this recent time of change. Large scale international recruitment is clearly off the policy agenda, and intakes to training are being reduced.

Debate about how many redundancies are occurring risks distracting from the equally important issues of how much reduced capacity there is in available nursing hours in the NHS now, and how much the reductions in future intakes are based on a realistic assessment of future need, rather than driven by current financial difficulties.

From Boom to Bust…or to Balance?

"One of the significant risks in the current financial climate is that trusts/SHAs will make short term cuts in the workforce and training commissions to effect current financial balance to the detriment of medium and long term planning. For some staff groups an ageing workforce and decreased participation mean that workforce supply is forecast to fall and that training commissions need to rise just to maintain existing workforce levels".
Workforce Review Team, NHS England, June 2006[33]

The critical issue facing the NHS in all four UK countries is how to manage the transition to different levels of funding without undermining the attainment of mid to long term planning objectives. Can a return to the old boom/bust cycle of workforce planning be prevented, and can a more sustainable, effective and balanced approach be achieved?

This year, the Labour Market Review has charted a rapid change in the headlines related to the NHS nursing workforce, particularly in England. Early signs of problems were evident as last years review went to press; this year we have highlighted the short term negative

impact of financial deficits on NHS nursing staffing in some parts of the NHS. What is becoming clear, as highlighted in the quote above, is that short term cuts driven by financial difficulties are prejudicing the future supply of sufficient staff to meet planned requirements. The Workforce Review Team, in their provisional recommendations for 2007/8 highlighted that "SHAs should aim to maintain nursing pre-registration commission levels close to those of 2005/6, as far as possible, within the constraints of local finances and priorities in 2007/08"[34].

In assessing the dimensions and impact of these changes, we cannot rely on much of the official data, which is already 9 months out of date, at best, and does not enable a good fix on a rapidly moving target. Indicators of the dynamics of the labour market, such as vacancy rates, turnover and use of temporary staff are either too old or are open to different interpretations, and therefore not totally reliable as a sign of the impact of financial deficits.

Neither can we rely on official sources for clarity, completeness and consistency in strategic oversight and direction of workforce planning. Given the plurality of providers there is a real need for a stable and robust workforce planning and development strategy and infrastructure, but we see it at its most diffuse for several years. The national HR director post in the NHS in England was unfilled for several months, until recently, some of the senior new SHA posts are not yet filled, and changes in roles and responsibilities of the reorganised fewer, larger SHAs in relation to HR and workforce planning responsibilities have not yet been fully detailed.

Workforce planning in the NHS in England is currently subject to a House of Commons Health Committee Inquiry, and many of the organisations providing written and oral evidence to the Inquiry have highlighted their concerns about future direction, future funding and future responsibilities[35]. In contrast, the approach to nurse workforce planning

in some other parts of the UK appears more stable and evolutionary- for example, the SNIP approach in Scotland has now been in operation for more than a decade[36].

The extent to which the financial impact has lead to “real” redundancies of NHS nurses and other staff is an issue, but should not be the only focus for concern, even when it does reflect difficult times for nurses trying to develop their careers. There are three major underlying factors which must be addressed if the NHS in England and in the other UK countries is to have a period of greater stability for planning and services delivery. Firstly there has to be a recognition that redundancies are not the only negative effect on staffing of the current deficits. Ending temporary staff use overnight, as a cost saving measure, or “freezing” a post will also have a pronounced effect on the delivery of care, and can lead to a reduction in available nursing hours. Some of this may be covered by current staff working additional hours; but none of these responses speak of a robust, sustainable or strategic way forward.

The second point to make is that workforce planning, for nurses and other groups in the NHS in England, cannot become more effective until there is greater clarity about the shape of services, and the structural framework in which planning must be conducted. Issues such as payment by results, patient “choice” and the strategic shift from acute to primary care all have major implications for workforce planning and development, as does the role and impact of the independent sector as an employer and provider of NHS care, and the growing number of foundation trusts.

The NHS in England is moving into a much more uncertain period, when workforce planning will be much more difficult, but no less necessary. What is certain is that the level of funding available for the NHS will drop back to historic levels of growth[37], after the unprecedented levels of planned growth that have been evident in recent years. The question that remains is, can a planning framework be maintained that is robust enough to deal with

the funding constraints, but flexible enough to accommodate a mixed and changing profile of employers in the labour market?

The final point is that primary care is highlighted as the priority way forward, in policy terms[38], yet is not given sufficient workforce planning and development attention. Community nursing will carry a major responsibility for delivering any change and growth in this sector. Yet the community nursing workforce is much more vulnerable to the impact of ageing, and has not been amenable to the quick fix of international recruitment. Proposals to retrain acute care based nurses for community care, to create a direct route for newly qualified nurses into primary care work[39] or, as in Scotland, to end the distinctions between district nurses, health visitors and school nurses in favour of a new role of “community health nurse”[40] have not yet been fully debated or enacted. The workforce planning implications of such changes are significant. The NHS Workforce Review Team in England has noted that “SHAs should recognise the implications of more activity being carried out in primary care, in their influence on training activity, development of first job roles in the community and the retraining and transfer of staff from secondary care”[41].

Short term NHS funding problems may distract from, but do not in any way alter the impact of, demographic changes on future workforce requirements. The only question that remains is how the NHS will choose to deal with these problems. If workforce planning is to support the attainment of NHS service targets it will have to look beyond the immediate distraction of funding deficits, and assess how to deal with the underlying issue of ageing of the workforce. In particular it will have to address the critical issue of ageing in the community workforce.

3. The Profile of the UK nursing workforce

This chapter of the report provides an overview of the UK nursing workforce, drawing from data from official sources. It looks first at trends in student numbers, and then profiles the nurses in employment. As noted in the introduction to this report, the rapid recent changes impacting as a result of NHS financial difficulties in England have not yet been captured in this data, most of which relates to 2005. This section should be reviewed in the knowledge that it presents primarily a picture of the profile of the workforce one year ago, and cannot reflect fully the impact of these recent changes.

Nursing and midwifery pre-registration students

"There are indications that the current financial challenges facing the NHS are having a significant impact on decisions around training. It appears that some SHAs have reduced commissions and that the Deaneries have also been asked to prepare for a funding reduction……. NHS Employers believes that there is a need for stability in funding for training. We would not support hasty reductions in training commissions or cutbacks in post entry training budgets. Investment and expansion should be focussed on service priority areas. Overall spending levels on education should be protected where possible."
NHS Employers, March 2006[42]

In recent months much comment in the media and elsewhere has linked the financial deficits in parts of the NHS, to the employment prospects of newly qualified nurses and anticipated cuts in the numbers of training places commissioned for future years. In particular, there is concern that any reductions in numbers, or take-up, could trigger a new boom-bust cycle in the availability of newly qualified staff reminiscent of that experienced in the 1990s.

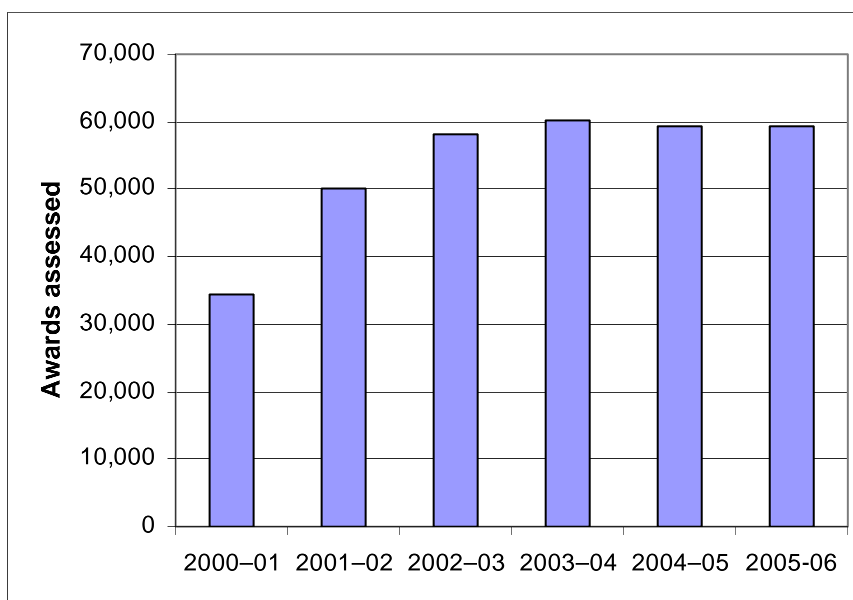
In this section we start by piecing together the limited data that is publicly available to establish the numbers currently in training, recent trends in the numbers of applications and entrants as well as dropouts and graduates. We then look at future numbers of training places and likely future outputs.

The student population

The overall number of pre-registration nursing and midwifery students in the UK is not clear. The most recently published figures from the Higher Education Statistics Agency are more than a year out of date. These show that, at the end of July 2005, there were 90,950 students on full-time (more than 24 weeks) ‘undergraduate’ nursing courses in higher education institutions across the UK, roughly four per cent more than in the previous year. However, these figures do not separately identify pre-registration nursing and midwifery education from other, post-registration (but still ‘undergraduate’), courses.

The numbers of pre-registration nursing students in receipt of non-means tested NHS bursaries (Figure 8) in England is known and provides the best clue to recent trends in the size of the student population. They show that the number of nursing students on NHS bursaries grew from around 34,000 in 2000-01 to a little more than 59,000 in 2005-06 (including 7,325 on nursing degree courses).

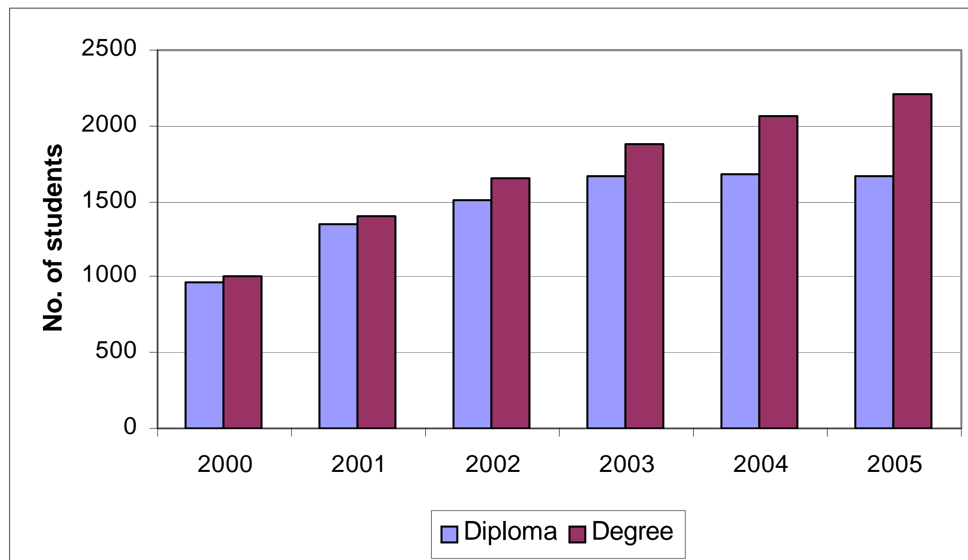
Figure 8 Numbers of pre-registration nursing students with NHS bursaries 2000-01 to 2005-06 (England only)



Source: House of Commons, Hansard, Written Answers, 13 December 2004 and 6 June 2006

Figure 9 shows the trend in NHS bursary awards to diploma and degree level midwifery students in England. In the academic year 2005–06 this has now reached over 3,800 (note figures include some 'nil award' holders).[43]

Figure 9 Numbers of NHS funded pre-registration diploma and degree midwifery students 2000 to 2005 (England)

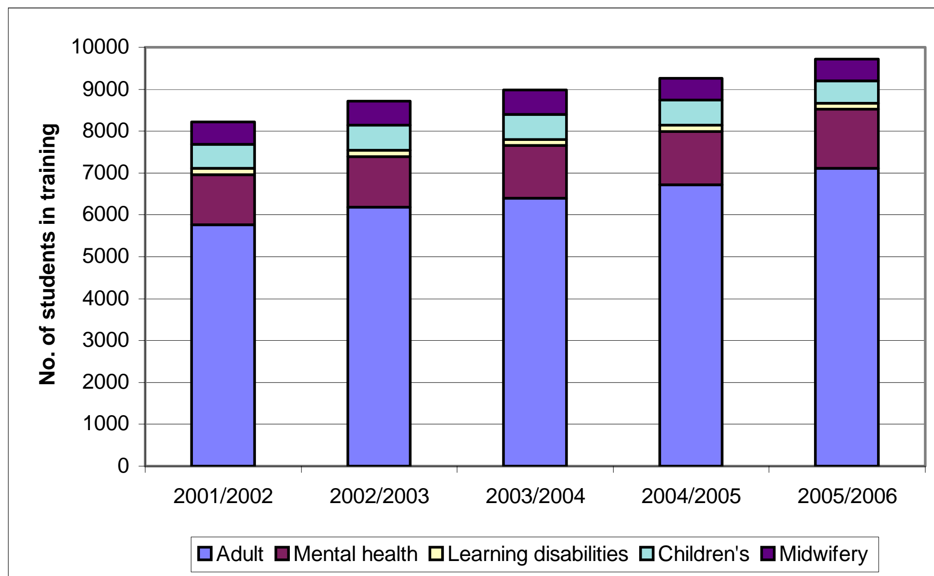


Source: House of Commons, Hansard, Written Answers, 18 May 2006

Approximately 15,750 pre-registration nursing and midwifery students are enrolled on courses in Scotland, Wales and Northern Ireland:

- there were 9,726 first level nursing and midwifery students in Scottish Higher Education Institutions at 31 March 2005, an increase of 5% (462) since March 2004 [44]. Adult branch students account for nearly three-quarters (73%) of this total (Figure 10).

Figure 10: Population of pre-registration nursing and midwifery students by branch, 2000/01 to 2005/06 (Scotland)

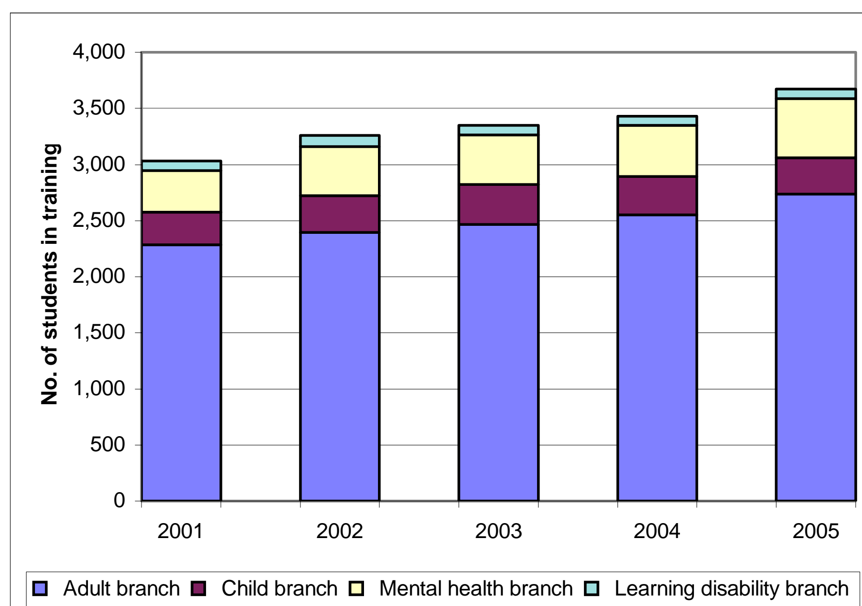


Source: ISD, NHS Scotland Workforce Statistics

- In Wales the in training population has risen by 21% since 2001 when there were 3,033 students to 3,672 in 2005[4]. Adult branch students account for three-quarters of this total[45] (Figure 11).
- There are approximately 2,349 full-time undergraduate nursing students in Northern Ireland.[46]

[4] Figures are for persons in training and paid for centrally. They include Bachelor of Nursing and those in direct entry midwifery training

Figure 11: Population of pre-registration nursing and midwifery students by branch, 2001 to 2005 (Wales)



Source: Health Statistics Wales 2006

Applications and intakes for diplomas

Since 1997, NMAS (the Nursing and Midwifery Advisory Service) has been contracted by the Department of Health to processes applications for full-length, diploma-level, pre-registration nursing and midwifery programmes currently offered by fifty universities and colleges of higher education in England. The latest statistical report shows that just under 36,000 individuals applied for entry to diploma courses, an increase of nearly 13% on the 2003-04 entry cycle and the largest number since 2001-02. Of the 34,347 valid applications received, almost half (16,771) were successful (Table 2). This is the largest number of successful applicants in a single year and the biggest annual rise (8% up on the previous year's figure).

Table 2 Applications for diploma level pre-registration nursing and midwifery programmes, 1999-00 to 2004-05 (England)

Entry cycle	Applications received	Application passed to institutions	% Change	Successful applicants	% Change	% Successful
1999-00	39,034	35,092	+7.9	14,819	-0.1	42.2
2000-01	45,677	41,169	+17.3	15,734	6.2	38.2
2001-02	37,314	34,162	-8.4	15,560	-1.1	45.5
2002-03	32,585	29,979	-8.0	15,810	1.6	52.7
2003-04	31,917	30,766	2.6	15,487	-2.0	50.3
2004-05	35,970	34,347	11.6	16,771	8.3	48.8

Source: NMAS

However, this high level picture hides significant variations at branch level in terms of the number of applications and acceptances and the direction of trends (Table 3). Over half the applications and more than two-thirds (69%) of acceptances are for adult branch. Applications and acceptances for the adult branch both grew (18% rise in applications and a 12% rise in acceptances) as did the mental health branch (applications up 13.5% and acceptances up 7%). In contrast, learning disability branch saw both a fall in applications (down nearly 3%) and in acceptances (down by more than 10%), while midwifery had the largest percentage rise (24%) in numbers of applications but also the largest fall in acceptances (14%).

Since 2000 the overall proportion of applications accepted has increased from about one in seven (15%) to just over one in five (21%). Applications for some branches have a much higher success rate than others (Table 3). For example, less than 6% of applications to midwifery were accepted, compared with almost 27% of applications to the adult branch.

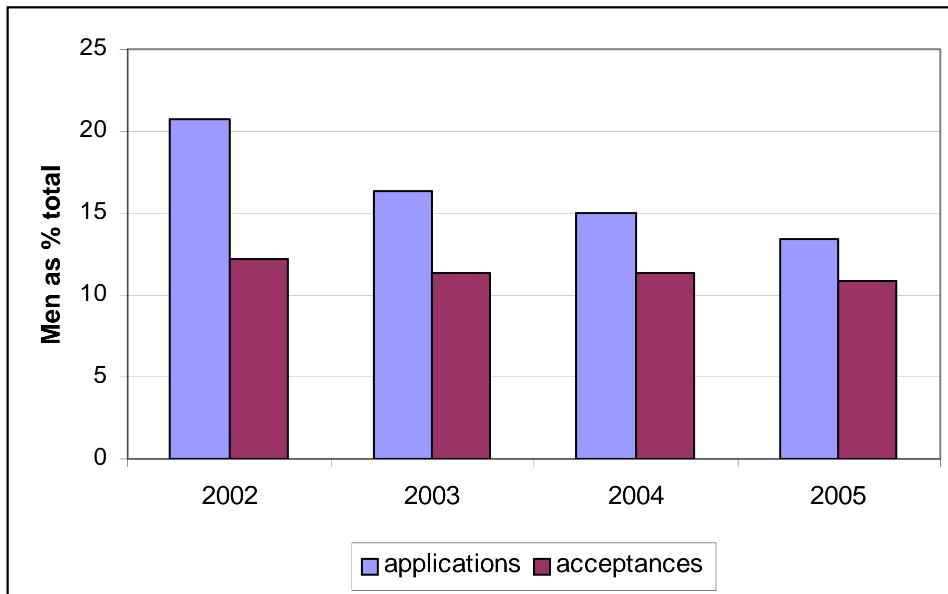
Table 3: Applications and acceptances for full-length diploma level pre-registration nursing and midwifery programmes in England, 2000 to 2005, by branch

		2000	2001	2002	2003	2004	2005
Midwifery	Applications	6880	6830	5846	5847	7304	9,082
	Acceptances	488	526	556	609	600	516
Adult	Applications	46883	57405	45384	36843	36473	43,188
	Acceptances	9422	9951	10357	10347	10379	11,602
Mental Health	Applications	17313	22382	16204	12979	13236	15,024
	Acceptances	2310	2457	2425	2540	2594	2780
Learning disability	Applications	3626	4612	3241	2301	2162	2,106
	Acceptances	607	668	545	568	521	468
Child	Applications	17038	19165	15759	11841	11193	11,605
	Acceptances	1384	1431	1436	1535	1369	1405
CFP	Applications	4839	5724	843	505	87	0
	Acceptances	608	701	241	211	24	0
TOTAL	Applications	96579	116118	87277	70316	70455	81005
	Acceptances	14819	15734	15560	15810	15487	16771

Source: NMAS

Two other key trends are apparent in the figures. Firstly, there has been a fall in the share of applications from men (Figure 12) – down from 15% last year to just over 13% of the total – and in their share of acceptances (down from 11.3% to 10.9%). And, men are increasingly concentrated in the mental health and learning disability branches which now account for 47% of accepted male applicants (compared with 42% in 2002).

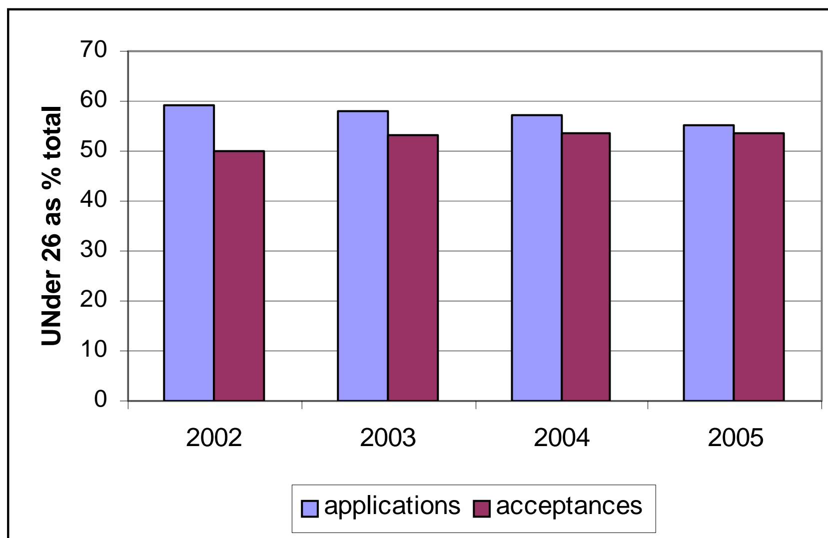
Figure 12: Male % share of applications and acceptances for full-length diploma level pre-registration nursing and midwifery programmes in England, 2002 to 2005



Source: NMAS

Secondly, despite a continuing drop in the percentage share of applications from those aged 25 and under (now 55% compared with 59% in 2002), younger people's share of accepted applicants is slowly increasing (Figure 13). In 2005 there were over 44,850 applications from students aged 25 and under, of which 8,967 were accepted. Nevertheless, older applicants are still marginally more likely to be accepted (22% compared with 20% of those aged 25 and under).

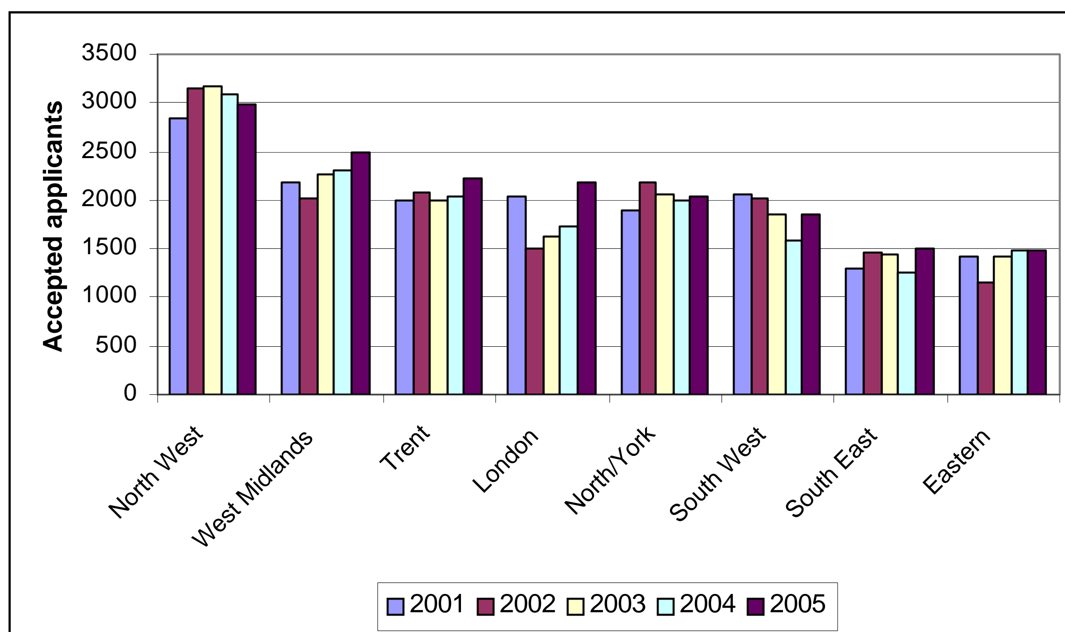
Figure 13 Under 25s % share of applications and acceptances for full-length diploma level pre-registration nursing and midwifery programmes in England, 2002 to 2005



Source: NMAS

The overall rise in the number of accepted applicants has not been felt evenly across the county. In particular, universities and colleges of higher education in London and the South East experienced increases of 26% and 20% respectively compared with a 3% reduction in the North West, no change in Eastern and growth of under 3% in Northern &Yorkshire (Figure 14).

Figure 14 Applications and acceptances for full-length diploma level pre-registration nursing and midwifery programmes in England, 2001 to 2005, by region of institution



Source: NMAS

- A continuing decline in the number and proportion of applications from outside England. In 2005 only 334 accepted applicants (2%) were from outside England. This includes 157 applicants from elsewhere in the UK (the largest number of these were from Wales) as well as others from Eire, other EEA and non-EEA countries.

No new data on intakes to pre-registration courses are available for Scotland since the 2005 labour market review. This reported that in 2003/04, the number of students commencing three year nursing courses had reached a new high of 3,608, up 4.6% on the previous year (Table 4).

Table 4: Scotland: numbers of students starting 3-year nursing and midwifery programmes, 1997/1998 to 2003/04

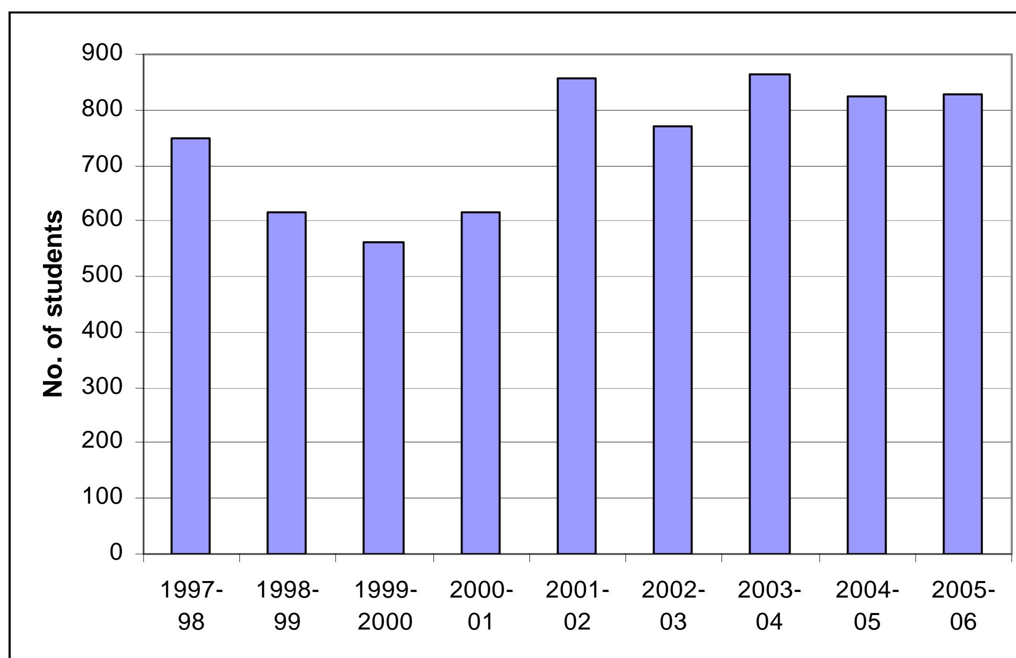
	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Adult	1 679	1843	1 891	2 203	2378	2414	2581
Mental health	428	441	463	539	510	486	567
Learning disabilities	80	102	86	68	50	66	61
Children's	180	214	235	226	222	217	213
Midwifery	171	183	191	206	205	212	186
Total	**2 538**	**2 783**	**2 866**	**3 242**	**3 365**	**3 395**	**3 608**

Source: ISD

This increase was accounted for by bigger intakes to the adult (up 3.7%) and mental health (14.8%) branches; commencements on the child and learning disabilities branches reduced (by 7.6% and 5.6% respectively) and numbers commencing the three year and 18 month midwifery programme have also fallen. Overall completions from three-year pre-registration nursing programmes were 2,568 in 2003/04. More recent figures have not been published.

Figure 15 shows the number of students who commenced pre-registration nurse training in Northern Ireland in each of the last 10 years, with over 800 new students commencing in each of the last three years. Successful completions have risen from just over 500 in 2000-01 to just over 700 in 2004-05.

Figure 15 Number of pre-registration nursing students who commenced training 1997/98 to 2005/06, Northern Ireland



Source: House of Commons, Hansard, Written Answers, 24 Apr 2006

Non-completions

The number of student nurses and midwives who withdraw from pre-registration education without completing their course is an important consideration in determining the future supply of qualified staff. In the past different definitions made it difficult to establish a clear picture. A new data collection system, administered by HESA has been used by the Department to 'forecast' attrition rates since 2002-03.[47] Nevertheless, robust up-to date figures remain elusive and there has been continued disagreement about the actual levels of attrition[48].Figures obtained from the four health departments by the Nursing Standard, and published early in 2006, gave estimates for attrition of 16% in England, 23.9% in Scotland, 9.2% in Wales and 6% in Northern Ireland.

In England, the most recent attrition rate for student nurses and midwives is 16 per cent and relates to a 'forecast' for the 2003-04 in-take year. Table 5 shows the number of pre-registration nursing students who have withdrawn from their university course since 1997-

98. The latest planning assumptions used by the DH in its NHS workforce demand and supply analysis to 2008/09 continue to use a 'wastage from training' assumption of 20%, somewhat higher than the estimate provided here.[49]

Table 5 Pre-registration nursing students withdrawing from courses, 1997-98 to 2003-04 (England)

Intake year	Withdrawing	
	No.	%
1997-98	3,287	20.16
1998-99(*)	2,938	18.16
1999-00(*)	2,338	13.44
2000-01(*)	1,035	6.21
2001-02	not available	
2002-03(**)	12,785	18
2003-04(**	10,300	16

Source: House of Commons, Hansard, Written Answers, 29 March 2006

Notes: (*) This data is not complete as it does not include withdrawal rates for each year of the course for the intake year specified; (**) this figure is a provisional estimate based on HESA data.

The Human Resources Performance Framework, published in October 2000, set a target of 13 per cent attrition (leavers) for those students entering training in the 2000-01 academic year. This figure is still quoted as the national target; however, the minister has stated that 'attrition rates are best determined in the light of local circumstances' and that the new national contract framework, which provides specific provision for local agreement to incentivise the reduction of attrition, is being introduced.[50] It is also expected that formalising the need for SHAs and HEIs to work with the placement providers to ensure good quality practical experience will reduce rates of attrition.[51]

In Scotland, the 2005 national workforce planning framework[52] suggests an 'average attrition rate of 22.9%' over three year cohorts. These figures (which probably include transfers between branches) are very similar to those of previous years and are not indicative of any

improvement. The report also suggests that around one in seven newly qualified nurses and midwives choose not to enter nursing employment.

The most recent published figures for Scotland relate to the 2001/02 entry cohort and, as such, are incomplete. Table 6 shows 'attrition' rates in excess of 20% a year for each of the complete years (1997/98 to 2000/01) and that these rates have been rising over time. At branch level rates of up to 35% are shown (learning disability).

Table 6 Attrition rates for students on nursing and midwifery diploma courses, 1997/98 to 2001/02, Scotland

	1997/98	1998/99	1999/00	2000/01	2001/02
Adult	20.4	21.0	23.3	23.4	29.8
Mental Health	25.1	22.7	24.7	29.3	27.6
Learning Disability	32.0	29.8	35.4	19.7	19.0
Children	30.0	24.9	20.7	20.8	22.6
Midwifery	22.2	29.1	25.0	24.9	23.9
All Categories	**21.7**	**21.9**	**23.5**	**23.9**	**28.0**

Source: ISD

The attrition rates for pre-registration nurse training in Northern Ireland from 2001-02 until 2004-05 (academic years) are shown in table 7.

Table 7 Attrition rates for students on pre-registration nursing courses, 2001/02 to 2004/05, Northern Ireland

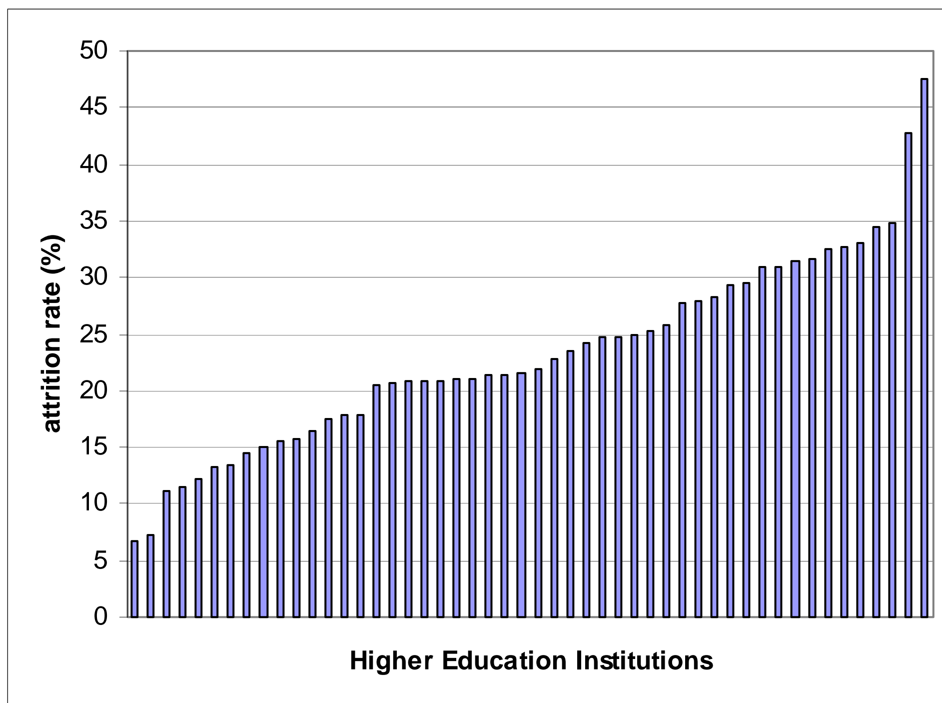
Academic year	Queen's University Belfast	University of Ulster
2001-02	8.0	12.0
2002-03	11.9	16.0
2003-04	14.7	10.0
2004-05	7.1	8.0

Source: House of Commons, Hansard, Written Answers, 13 March 2006

More recently, data released to the *Nursing Standard* under the Freedom of Information Act has cast doubt on the official figures. *Nursing Standard* requested attrition data from all 83 institutions across the UK that taught nursing courses between 2000 and 2004 (Figure 16). The figures reveal that out of 16,919 nursing students, who began diplomas expecting to finish in 2004, a total of 4,091 did not complete their courses.[53] This gives an overall attrition rate of 24.2 per cent. They also show:

- a wide range, from 7% to 47.5%, between institutions (Figure 13)
- Drop out rates were higher in London and southern England (30%) and in Scotland (26%) compared with the rest of England (22%) and Wales (15%)

Figure 16 Attrition rates from the 2004 diploma courses qualifying cohort



Source: data provided by the Nursing Standard

The same exercise also found that of 2,332 students starting 3-year degrees, some 636 (27%) did not complete, nor did 227 (30.5%) of the 744 who started 4-year degrees. The Council of

Deans argue[54] that it is not surprising that drop-out rates can be comparatively higher from nursing degree programmes because the average student age (27) is higher, their family circumstances create a range of financial and other pressures that can be greater than those facing more ‘traditional’ students, they enter programmes with a wider range of previous qualifications and that clinical placements expose students, at an early stage in their course, to the realities of working as a healthcare professional.

The *Nursing Standard* estimate that, with nurse training estimated to cost around £11,479 per year (including bursary) and most students who drop-out doing so during their first year, the annual cost of student nurse attrition in the UK is £56.9 million. The Department of Health is reported to have commissioned research from Skills for Health to examine the causes of nursing student attrition.[55].

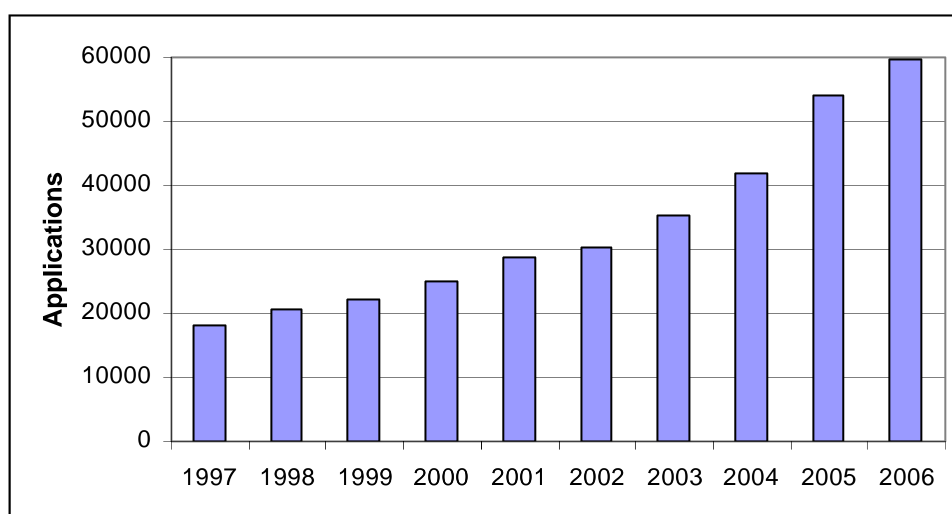
Even when students successfully complete their nursing education, there is no guarantee that they will then enter nursing employment in the UK. As part of its annual data collection on the 'first destinations' of leavers from higher education, HESA collected data on what pre-registration nursing and midwifery students who had successfully completed their course at a publicly-funded higher education institution in England between August 2003 and July 2004 were doing six months later[56]. Of the 80% (4,874) who responded, the majority (4,274, 88%) were employed as a nurse, 6% were employed elsewhere and 5% were not in employment.

More recently, in June 2006, responses from 20 universities to a survey conducted by the Council of Deans[57] found that less than 20% of qualifying nursing students had secured a post, compared with 70 per cent or more at the same time in previous years. The Council contend that feedback to those considering application for education in nursing and midwifery will be rapid and may result in reduced applications and that it may also raise attrition rates if students believe that they are unlikely to secure a post at the end of their course.

Degree level nursing

A key trend in recent years is the significant and continuing increase in numbers of applications for places on degree level nursing courses. By the deadline of 30th June 2006 there were 59,700 applications for undergraduate nursing degree places[58], 11.3% more than in the 2005 applications cycle and more than three times as many as in 1997 (Figure 17). This compares with a 2.8% decline in the overall number of applications for degree course places. Nursing is now the sixth most popular degree course in terms of numbers of applications; the top five all show static or declining numbers of applications. However, the rate of growth in applications (10.5%) has fallen for the first time since 2002.

Figure 17 Applications for undergraduate nursing degree course places, 1997-2006



Source: UCAS

Since each applicant may apply to up to six different courses/institutions, there can be large differences between the numbers of applications and the numbers of applicants. Numbers of applicants have also increased steadily. In 2005, they rose by more than 22%, to just under 14,750. As Table 8 shows, the majority (94%) are 'home' applicants, that is, they are domiciled in the UK.

Table 8: Number of applicants for entry to nursing degree courses by domicile, 2000-2005

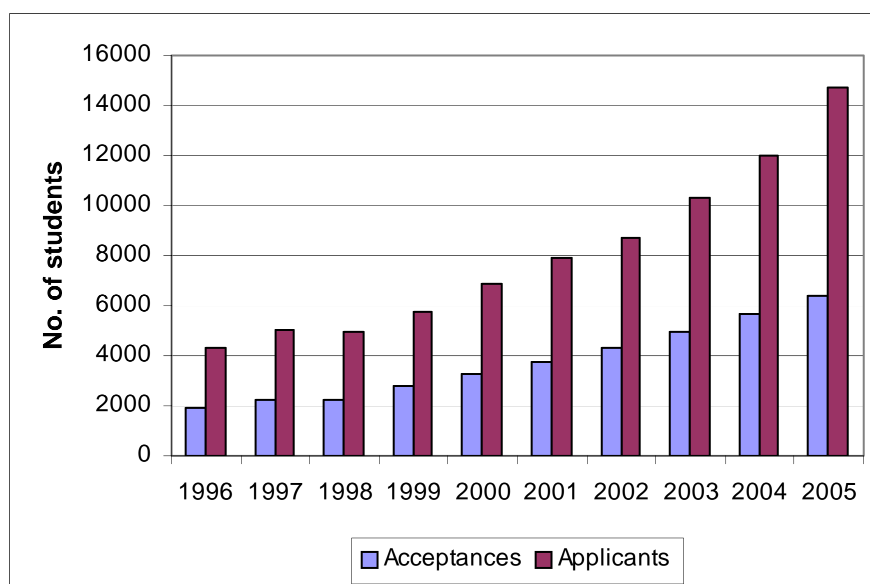
	2000	2001	2002	2003	2004	2005
Home	**6394**	**7169**	**8090**	**9488**	**11355**	**13878**
England	*5357*	*6126*	*6541*	*7515*	*8953*	*10988*
Wales	*473*	*525*	*783*	*1050*	*1343*	*1672*
Scotland	*308*	*280*	*346*	*362*	*385*	*460*
NI	*256*	*238*	*420*	*561*	*674*	*758*
Other overseas	322	508	428	393	347	400
EU	203	218	234	410	336	466
Total	**6919**	**7895**	**8752**	**10291**	**12038**	**14744**
% change	20.9	14.1	10.9	17.6	17.0	22.5

Source: UCAS

The majority (93%) of applicants for degree courses are women; male applicants have consistently remained at between 7% and 8% of applicants. More than three-quarters (79%) of these 'home' applicants were in England, a share that has reduced from around 84% in 2000 with more rapid growth in applicant numbers in Wales and Northern Ireland. The number of applicants in Scotland has grown more slowly than elsewhere in the UK. Numbers of applicants from other EU and overseas countries fluctuate from year to year but have remained broadly similar, and comparatively small.

The numbers of students accepted on to nursing degree courses has grown at a similar pace to the increase in applicant numbers (Figure 18). In 1996 (the first year for which these data are available) just under 2,000 students were accepted on to undergraduate nursing degree courses. By 2005 this figure had grown to 6,360, more than double the figure in 1999. However, the rate of expansion has slowed from between 14% and 15% a year in the early part of the decade to just under 12% this year. This compares with an increase of just under 8% in the overall number of undergraduates starting degree courses in 2005.[59]

Figure 18 Applications and acceptances for entry to nursing undergraduate degree courses, 1996-2005

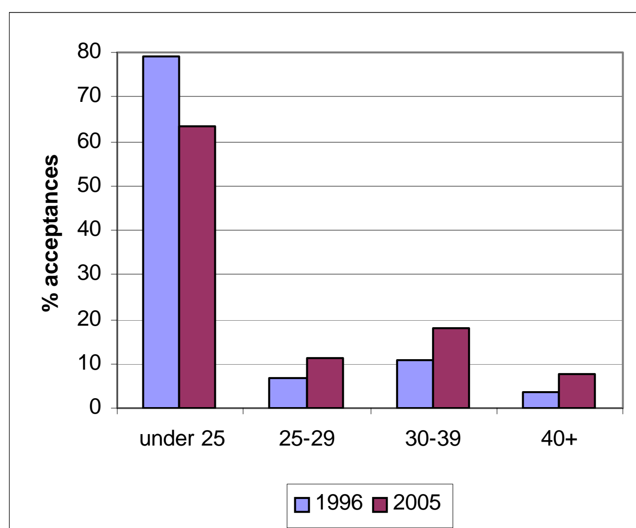


Source: UCAS

Two fifths (43%) of all applicants were accepted for entry in 2005. The proportion of applicants accepted is much higher for home students (45%) compared with EU (27%) and other overseas (6%) applicants. There are also significant differences between the four home countries, with a markedly higher 'success' rate for applicants from Northern Ireland (61%), Scotland (53%) and Wales (52%), compared with England (42%).

Alongside expansion in numbers of applicants and acceptances, there has been a marked shift in the age profile. In 1996 almost 80% of successful applicants were aged under 25 and fewer than 4% were aged 40 or over. Now, around 63% are under 25 and 8% are aged 40 or over (Figure 19). The age profiles also differ widely between the four home countries, with 60% or more accepted applicants in Scotland and Northern Ireland aged under 20 compared with 39% in Wales and 51% in England. In contrast 32% of successful applicants in Wales were aged 30 or over, compared with 25% or less in the other home countries.

Figure 19 Acceptances for entry to undergraduate nursing degree courses by age group, 1996 and 2005



Source: UCAS

This section has highlighted growth in applications and in the number of students entering pre-registration nurse education in the four countries of the UK in the period up to 2005/6, but with continuing concern about attrition rates. In the next section, we report on the profile of the registered nurse population in the UK.

The UK registered nurse population

In March 2005 there were 672,897 qualified nurses, midwives and health visitors registered with the NMC. Increased entries of new nurses from education and from overseas has meant that the overall population on the Register has increased in recent years.

This 'registered' population represents the pool from which the NHS and other employers recruit qualified staff. Over 30,000 registrants, about one in twenty, are resident overseas (these are nurses and midwives who qualified or registered in the UK and are currently recorded as living abroad). The "pool" population in the UK is therefore about 640,000.

The nursing workforce

The NHS is the main employer of nurses in the UK, but nurses also work in a range of other jobs and sectors. Data on employment in other sectors is limited, and has reduced in quality in recent years. The tables below provide estimates for the headcount and WTE for qualified and unqualified nursing and midwifery staff in the NHS in the four UK countries. Differences in definitions and in the allocation of different types of unqualified staff mean that direct comparison of these groups across the four UK countries is difficult.

There were approximately 473,000 qualified nurses and midwives (headcount) employed in the NHS across the four UK countries in September 2005 [approx 382,000 WTE] (Table 9). About seven out of every UK based ten nurses on the register were working in the NHS.

Table 9: Qualified Nursing and Midwifery staff (headcount and whole-time equivalent) employed by the NHS in 2005 (UK)

	England	Scotland	Wales	N.I.	Total
WTE	307,744	39,837	20,698	13,345	381,624
Headcount	381,257	46,594	29,415	15,638	472,904

Sources: Department of Health, ISD Scotland, Welsh Assembly, Northern Ireland HRIS
Note: Figures are for September (March for N.I)

In addition, there were approximately 166,000 unqualified nursing staff [120,000 WTE] (Table 10).

Table 10: Unqualified Nursing staff (headcount and whole-time equivalent) employed by the NHS in 2005 (UK)

	England	Scotland	Wales	N.I.	Total
WTE	93,405	15,243	7,214	4,017	119,879
Headcount	128,325	19,096	13,519	4,674	165,614

Sources: Department of Health, ISD Scotland, Welsh Assembly, Northern Ireland HRIS

Note: Figures are rounded. Figures are for September. Figures for Scotland are “non registered”, excluding nursery nurses and healthcare assistants. Figure for England is “Nursing auxiliary/assistant”. Figure for Wales is “nursing assistant/ auxiliary”. Figure for Northern Ireland is “unqualified nursing”. Table excludes Health Care Assistants, where these are separately identified in national data.

Health Care Assistants

Health Care Assistants (HCAs) are an increasingly important part of the healthcare workforce, often working under the supervision of nurses alongside "traditional" unqualified nursing staff. HCA receive training and are vocationally qualified. Some HCA's are actually nursing students; a recent survey reported that one in ten student nurses were working shifts as HCA's for financial reasons[60]. Others previously worked as nursing auxiliaries.

Despite their growing significance within the NHS, it is difficult to assess completely and accurately the size of the HCA workforce in the NHS. Data is available on the NHS in England, and in Wales, but data in Scotland suggest very few are employed (this may be because they are not identified as HCA's, but as "assistant" nurses), and national data in Northern Ireland does not identify separately any HCAs. The table below sets out what is reported at national level in England, Scotland and Wales.

Table 11: Healthcare Assistants (headcount and whole-time equivalent) employed by the NHS in 2005 (Great Britain)

	England	Scotland	Wales	GB Total
WTE	33,183	23	2,598	35,804
Headcount	39,522	25	4,232	43,799

Sources: Department of Health, ISD Scotland, Welsh Assembly.
Note: Figures are rounded. Figures are for September. National data for Northern Ireland does not identify HCAs.

As noted earlier in the report, there has been rapid growth in HCA numbers in England, more than doubling since 1997, when there were 16,190 wte reported in the NHS. In the same period, there has been very low growth in the number of traditional nursing auxiliaries employed in the NHS in England- about 10%.

GP Practice Nurses

In addition to those registered nurses working in NHS hospital and community health services, approximately 16,000 registered nurses (wte) are employed as practice nurses in England, Wales and Scotland. (Table 12).

Table 12: Number (wte) of practice nurses, by country, 1990 to 2005

	England	Scotland	Wales	GB total
1990	7738	584	418	8740
1991	8776	647	524	9947
1992	9121	744	519	10384
1993	9605	748	552	10905
1994	9099	768	582	10449
1995	9740	858	622	11220
1996	9820	875	637	11332
1997	10080	901	642	11623
1998	10360	968	665	11993
1999	10690	1003	698	12391
2000	10710	1065	713	12488
2001	11160	1097	738	13018
2002	11998	1181	773	13954
2003	12967	1211	N/a	-
2004	13563	N/a	795	-
2005	13793	N/A	847	-

Source: Health Statistics Wales, ISD Scotland, and DH

Non-NHS nursing

Nurses are employed in several sectors outside the NHS. These include: nursing and residential homes; independent hospitals and clinics; independent hospices; nursing agencies; and public sector services (prison service, defence medical service, higher education, police service, local authorities). A detailed and accurate identification of how many nurses are employed in these sectors is not currently possible. The information that is available is incomplete and is contained in disparate sources, uses a variety of definitions and is prone to double counting. Data on nurses working in the independent sector is markedly less complete than it was in the earlier part of the decade, when the Department of Health in England collated headline numbers information on nurses

working in nursing homes and in independent acute hospitals. In 2001, the last year data was collated; about 50,000 registered nurses (wte) were reported to be employed in private hospitals, homes and clinics in England.

Ethnicity

Comparatively little information is available on the ethnic composition of the nursing workforce. Improving the recruitment of minority ethnic students and staff into nursing and midwifery has been a policy priority for the NHS. Until the mid 1990s, no national data were routinely collected, and the introduction of new ethnic codes in England in 2002 makes trend analysis difficult.

The new dataset estimates that 18.9% of qualified nursing, midwifery and health visiting staff working in the NHS in England in September 2005 were from minority ethnic groups. The three largest categories by ethnic code were "White" (262,000), "Black or Black British" (23,000) and "Asian or Asian British" (22,000). However the ethnic origin of 14% of qualified nurses in the NHS in England was reported as 'unknown'. Data from ISD in Scotland reports a lower level of ethnic minority participation; data from Wales highlights that the ethnic origin of almost one third (9,000 of the 30,000) qualified nurses and midwives was "not known" or "not stated"[61].

The survey of RCN members in 2005[62] reported that about 10% of respondents were from ethnic minorities (but many were internationally recruited nurses). The survey also found that nurses from ethnic minorities were more likely to change jobs because of negative reasons (often associated with bullying and harassment) than white nurses. The survey also reported that nurses from ethnic minorities were more likely to have a second job.

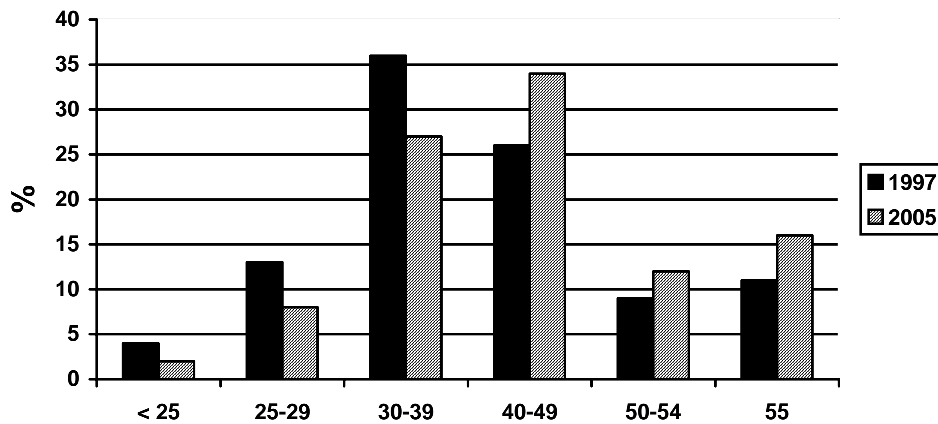
The NHS and other employers must ensure that their employment practices and provision of career opportunities are non-discriminatory. As part of this process, and to improve

recruitment in urban areas in particular, there is a need to facilitate career routes into health sector employment, including nursing, that are more readily accessible to the populations in inner city areas in London and other urban areas, many of which will be from ethnic minorities[63]. In 2004 the Department of Health in England announced that it was to provide £9 million to fund nine projects, one of whose aims is to recruit more nurses from black and minority ethnic groups[64].

A Shifting Age Profile

Against the backdrop of increasing financial uncertainty in the NHS, another looming workforce challenge can be identified with total certainty- that of the ageing of the UK nursing population. A key shift in the nursing and midwifery population in recent years has been the ageing profile. In 1991 one in four (26 per cent) of all those on the Register were aged under 30; by 2004/5 only about one in ten were under 30. At the same time, the proportion of registrants aged over 55 has grown from 9 % to 16 %. More than 100,000 nurses on the register are aged 55 or older, and a further 80,000 are aged 50-55 (Fig 20).

Fig 20 : Age profile, UK Nursing Register 1997 and 2005



Source: NMC/UKCC

The significance of this age-shift is threefold:

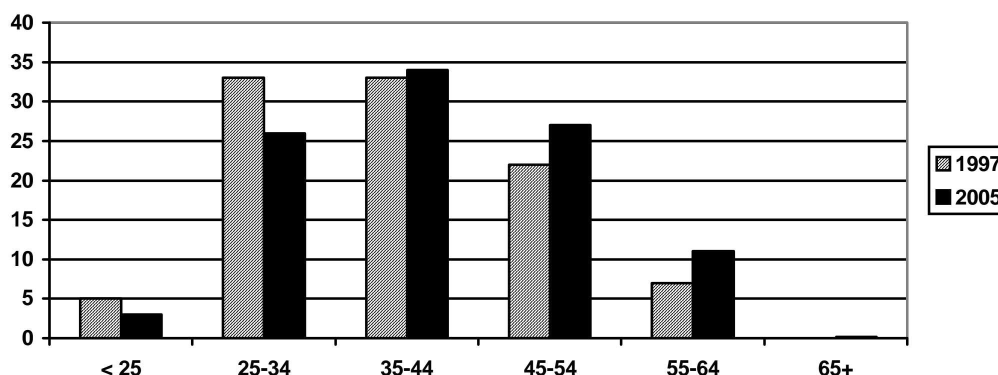
- Firstly, the numbers of registrants leaving the register is bound to increase as the large cohorts aged 50+ age over the decade. It has previously been reported that the "peak" years for leaving the Register are 35 to 39 and 60 to 64[65].

- Secondly, it is likely that fewer of the 'older' nurses who remain on the Register are likely to actively participate in the nursing labour market

- Thirdly, those older nurses who do participate are less likely to work full time. The RCN membership survey in 2003 reported that the proportion of nurses working full-time fell from 86 per cent of those aged under 30, to 54 per cent of those aged 50 or older.[66]

Paralleling the age profile on the Register, there has been a marked ageing in the NHS nursing workforce (Figure21), partly a result of the reductions in student nurse intakes in the early/ mid 1990's, and partly as a result of the emphasis on attracting returners.

Figure 21: Age profile of NHS qualified nurses, England, 1997 and 2005

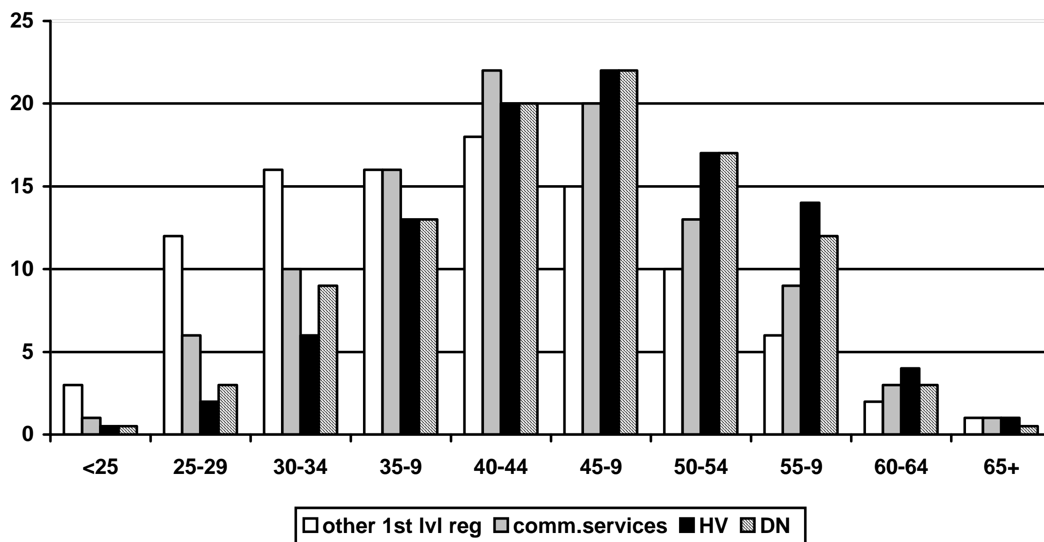


Source: Department of Health/ The Information Centre, NHS

The difference in age profiles between nurses on the NMC Register and nurses in the NHS workforce can be explained by the withdrawal of older nurses from NHS employment; and the older age profile of nurses working in some of the non-NHS sectors, particularly nursing homes and practice nursing. These sectors are likely to experience more pressure in the short term. But, as a consequence, the NHS may experience greater competition from non-NHS employers as they seek to replace retirees. In 2006 the NHS Workforce Review Team forecast that retirements of qualified nurses in the NHS in England are expected to double by 2010[67].

NHS Community nursing will be particularly vulnerable to the impact of ageing and retirement. District nurses and health visitors have a markedly older age profile than other registered nurses; the age profile of "other" community nurses is also older than that of registered nurses working in the acute sector (Fig 22). This means that the impact of growing retirements will hit the community sector earlier and harder.

Fig 22 : Age profile, NHS community nurses, Health visitors, district nurses, and "other" 1st level registered nurses,England, Sept 2005



Source: Department of Health/ The Information Centre, NHS

With 180,000 registrants aged 50 and older, the challenge of meeting the need to replace those who retire - or delay their retirement- will become increasingly prominent as the decade wears on. There have been a series of policy research papers in recent years which have focused on the issue of the ageing nursing workforce [68 69 70]. These papers have generally come to the same conclusions, that more needs to be done to 'age-proof' employment policy and practice in the NHS and other sectors to encourage the retention of older nurses at work, and that pension provision has to be made more flexible to support a more phased approach to retirement.

There have been previous policy led attempts to encourage more nurses to stay on in NHS employment up to and beyond their potential retirement date [71 72]. More recently, the NHS Pensions Scheme had come under a full review, with recent agreement to maintain a final salary scheme, but with greater contributions from employees.

It was announced in October 2005 that the government had "dropped" the proposal that staff currently employed in the public sector should have their retirement age increased to 65, and that a higher retirement age will be phased in for new entrants [73]. As yet it is unclear what impact this may have on retirement behaviour of current staff or on the future attractiveness of NHS nursing as a career. There is an urgent need for more detailed information about retirement behaviour of nurses, and what policy factors may affect that behaviour.

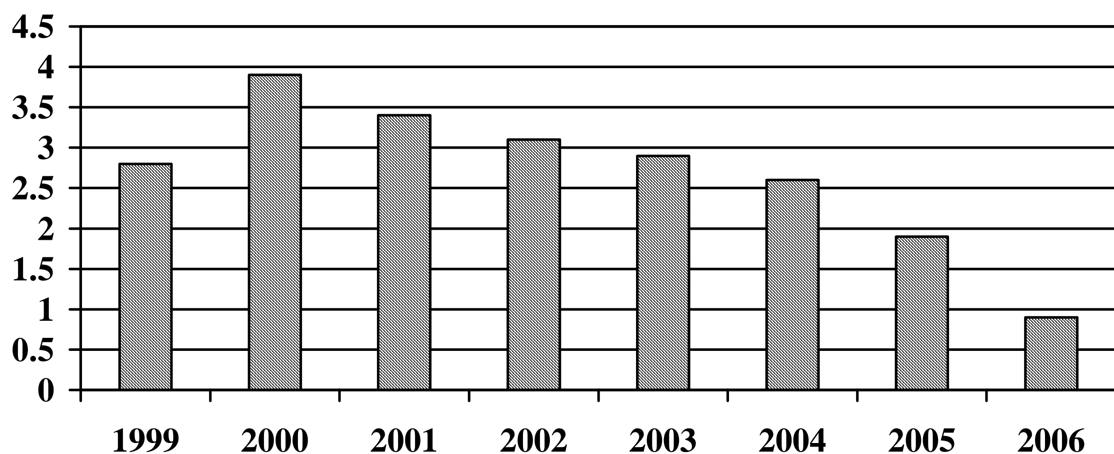
Indicators of change in the nursing workforce: Vacancy rates

One measure of change is the vacancy rate. The most recent vacancy data available is for March 2006 in the NHS in England, and co-incides with the period when financial difficulties were impacting on staffing in the NHS. Funded but unfilled posts which are recorded as vacant may give some indication of the number of nursing jobs that are "hard to fill" because of staffing movement or shortages. However posts may be deliberately held vacant to

contain staffing costs, as is happening in some NHS trusts in England where there are financial difficulties[74]. The Review Body has noted the various limitations with the vacancy date and has suggested that "It is therefore more useful to focus on trends rather than absolute levels".[75]

Long term trends in vacancy rates in England appear to be declining (see Figure 23), having dropped year on year since 2000. The reported rate was 0.9% in 2006, down from more than 3% at the beginning of the decade.

Fig 23: 3 month vacancy rates:qualified nurses, NHS England (% at March 31st) (source: DH 1999 -2005;IC, 2006)



Source: Department of Health

In 2005, the Healthcare Commission study on ward staffing reported vacancy rates at ward level in medical care, critical care, surgery and paediatrics of 8%- 9%, with higher rates reported in London and the South East[76]. Similar findings were reported by the Healthcare Commission report on Accident and Emergency Services, which highlighted overall nurse vacancy rates of 8-16%[77]. This was in contrast to the NHS "official" three month rate of 1.9% at that time (Table 13).

Table 13: Three month vacancy rates (% of total WTE) for qualified/ registered nurses, 2005, and 2006, GB (March).

	2005 (%)	2006 (%)
England	1.9	0.9
Scotland	1.7	N/A
Wales	2.0	1.1

Sources: England: NHS Vacancy survey 2005/ 2006; Scotland data - ISD Workforce Statistics; Wales –Health Statistics Wales, 2006, Chapter 14.
[Note: Northern Ireland vacancy data is not published separately for qualified nurses]

Indicators of Change: Use of Temporary staff

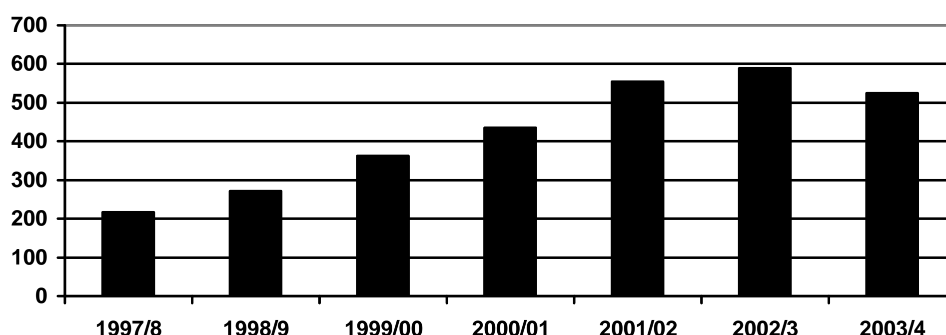
The extent to which the NHS continues to be dependent on the use of temporary staff may be one indicator of persistent shortages in specific locales. There are situations where the use of bank or agency staff can be effective, such as for short term cover of absent permanent staff, but long term or high level use of agency staff is costly, and may reflect organisations' inability to recruit permanent staff or manage their deployment effectively. There are three sources of temporary staff utilised in the NHS- "in house" nurse banks, agency nurses provided by external private companies, and "NHS Professionals", which was set up in 2001 as a national body to act as a source of temporary staff in England.

Assessing the extent of temporary staff use in the NHS is constrained by the limited data available, and by the fact that the published data does not cover all three types of temporary provision. The National Audit Office, which recently examined the use of temporary nurses in the NHS in England, noted that the Department of Health "does not have sufficient data to fully understand the extent and costs of using temporary nursing staff"[78]. The NAO noted that the NHS has "slightly reduced" total expenditure on temporary nursing staff (from 10% of total nursing paybill costs in 1999-2000 to 9.4% in 2005-6) and estimate that total expenditure

on temporary nursing staff reduced from £830 million to £790million between 2003/4 and 2004/5[79]. There was a switch in patterns of expenditure behind this headline figure- with a drop in expenditure on agency staff and an increase in expenditure on NHS Professionals.

Longer term trend data (but using a different method of calculation than NAO) was provided in response to a parliamentary question in 2005. This showed a reduction in expenditure on temporary nursing staff in the NHS in England in 2003-4, after consistent year on year increase in expenditure since the mid 1990's (Fig 24) . Annual expenditure more than doubled, from £216 million in 1997-8, to £590 million in 2002/3, before reportedly reducing

Figure 24: Non NHS staff (agency etc) by NHS classification, salaries and wages expenditure, England (£ millions)



Source: Hansard, House of Commons, Written Answer 12 July 2005, Col 975W

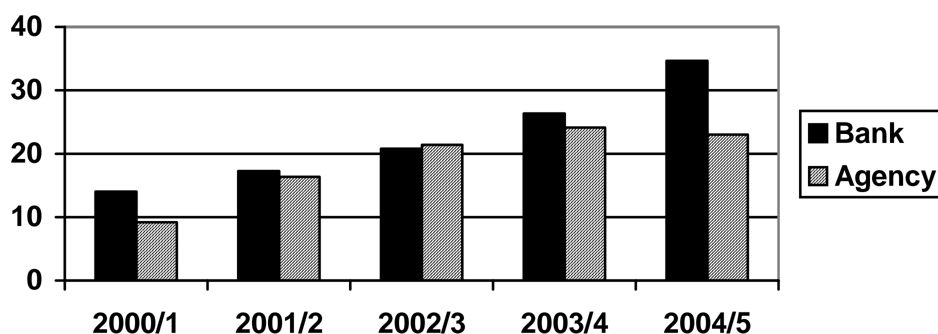
to £525 million in 2003-4 [Note: it is unclear how much, if any, of the expenditure on NHS Professional staff is included in these data].

The Healthcare Commission survey of ward staffing reported that in 2003/4, 15% of nursing staff expenditure was on bank and agency staffing, that the figure remained "stubbornly high" but with early indications of a drop in 2004/5, and clear evidence of a switch to more use of bank and NHS Professional staff rather than agencies. In its report on temporary nurse staffing in the NHS, the National Audit office (NAO) noted that the Department of Health

had stated that "it believes replacing temporary staff with experienced permanent staff leads to increased productivity and better patient care"[80].

The NHS in Scotland reported that expenditure on qualified agency and bank staff more than doubled between 2000/1 and 2003/4, exceeding £50 million in 2003/4. In 2004/5 there was a reduction in agency spend of approximately £1million, but an increase in spending on bank nurses of £8 million. Total expenditure on bank and agency exceeded £55million. (Fig 25).

Fig 25: Costs of use of bank and agency registered nurses, NHS Scotland, 2000/1 to 2004/5 (£ millions)



Source: ISD Scotland, 2005

The focus on reducing expenditure on temporary staff- particularly external agency staff- has become more pronounced in the NHS in the last two years. The NHS in England has promoted the use of framework agreements with staffing agency suppliers; in December 2005 the Department of Health highlighted controlling expenditure on temporary staff was high as one of ten "high impact" workforce changes[81], and in June 2006 NHS Employers issued a new briefing on making more effective use of temporary staffing[82]. In Scotland the NHS published an Action Plan in 2005, requiring all Health Boards to set targets to reduce agency staff use and to consolidate the organisation of nurse banks at Board level.[83]

As noted earlier, reducing, or ending the use of temporary staff was the single most commonly reported method of dealing with financial deficits in a survey of NHS trusts in January 2006. The NAO has noted that "Reductions in agency expenditure are being used to achieve financial balance but unless properly managed this could lead to additional pressure on permanent staff"[84].

The extent of any recent rapid change in UK nursing labour market dynamics cannot yet be assessed using official data. There are a range of factors impacting, some of which may have a positive impact on the UK nursing labour market, others which may be negative or have unintended consequences. Applications to nurse education were increasing up to the early part of this year, but this largely pre dates the recent period of vacancy freezes and reports of newly qualified nurses experiencing difficulty in obtaining NHS employment, which may have a negative impact on applications.

The effect of a more "mixed economy" of providers in the NHS, particularly in England, cannot be assessed given the paucity of data, but is creating a more challenging environment for workforce planning and policy. International recruitment rose quickly, and has fallen as rapidly, as a main policy option. Agenda for Change, the new pay system for nurses and other NHS staff is now near full implementation and may have a range of impacts on labour market behaviour. New roles for nurses and other NHS staff are being introduced. These are all significant changes, which cannot be fully measured, as yet. What can be highlighted using the available data is the impact of continued ageing in the UK nursing population, which will keep retention and supply issues on the workforce policy agenda.

Annex 1: Mind the Information Gap: Growing the Workforce

Things we need to know	***The reality***
1) We do not have accurate UK wide attrition rates during pre-reg nursing and midwifery education.	***A common definition has been agreed in England for common measurement but there is currently no complete and comparable data across the UK.***
2) We do not know with any accuracy how many newly qualified nurses and midwives take up employment in the NHS or elsewhere..	***No improvement: has been made more problematic because of changes in student indexing***
3) We have little published evidence of the actual retirement behaviour of nurses; a vital issue given that so many are in the 50+ age group.	***Little improvement: and the issue is now even more significant because of ageing workforce and proposed changes in NHS retirement scheme for future entrants..***
4) We have no accurate knowledge of how many of the growing number of overseas registrants are actually working in the UK, or where they are based.	***No improvement. NHS in England does not record how many international nurses it employs, despite this being recommended by House of Commons Committee. No accurate information on outflow of nurses from the UK.***
5) We have only scant information on the "cross border" flows of nurses between the four UK countries - this is likely to become a growing issue with devolved government and diverging health policies in the four countries.	***No improvement in published information***
6) We have no recent detailed information on the actual number of "re-entrants" who stay working in the NHS after refresher training, where they are working, and the hours they work	***Worsened. Return to practice data no longer collated in national level in England.***
7) We do not have consistent or complete information on vacancy rates across the four countries to assess the impact of shortages	***No improvement; and more questions being asked about relevance of "point in time" 3 month vacancy rate.***
8) We do not have complete data on flows of "joiners and leavers" in the NHS to assess with any accuracy the current sources of recruits and destinations of nurses leaving the NHS.	***No improvement in England; major source is OME sample survey, with worsening response rates.***
9) We have only scant information about the dimensions of the growing non-NHS nursing labour market and the "flows" of nurses between the NHS and other nursing employment.	***Worsened. Data no longer collated nationally in England***
10) We do not have UK wide information about the ethnic composition of the UK nursing population or workforce, to enable any assessment for potential to recruit, or to monitor equal opportunities in employment.	***Attempts at improvement, but changes in definitions, and large "unknown" response rate limit utility of data.***

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