

Difficult times, difficult choices

The UK nursing labour
market review 2009

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James Buchan

Ian Seccombe

1. Difficult times

This report is the 2009 review of the UK nursing labour market (LMR) commissioned by the Royal College of Nursing. In the twelve months since the last LMR was published the UK has entered full economic recession. This has raised major concerns about labour market impact, and about future NHS funding streams. There is growing consensus that the NHS is moving into its most difficult funding period for many years, and that this will have significant effects on nurses and on nursing labour markets.

Our 2008 report highlighted that the nursing labour market was in a period of uncertainty, with signs of redundancies and recruitment freezes emerging in some parts of the NHS, particularly in England. It is now clear that these signs of labour market trouble heralded an even more challenging period. In this first chapter of the review we consider the recessionary impact on the UK nursing labour market and on current approaches to determining nurse workforce policy and planning; in particular we stress the need for an improved evidence base to inform effective policies at a time of tightened NHS funding. In the second chapter we review recent trends in the nursing workforce, In the third chapter we consider the next generation of nurses-how many students is nursing education attracting and how many can it afford. In the final chapter we pinpoint the need to maintain a long term planning vision at a time of short term pressures.

The current financial impact of recession on the NHS has been termed by the NHS Confederation as ‘the greatest ever leadership challenge for the NHS’; it has highlighted that ‘with little or no cash increase from 2011/12 the NHS will need to plan for real term funding to fall by 2.5- 3 per cent per annum...it is unavoidable that this will also translate into fewer staff’¹. The King’s Fund has estimated that NHS productivity will need to make a step change from an annual average of -0.4% to an annual average of over 5%². In a labour intensive sector such as health, much of the policy attention on improving productivity will inevitably focus on the workforce.

In August 2009, Monitor, the organisation responsible for assessing foundation trusts (FTs), which now comprise about half of NHS provision in England, reported that

‘three year plans submitted by NHS foundation trusts to monitor may prove to be optimistic given the potential funding challenge ahead’. Monitor noted that ‘we are concerned that the plans prepared earlier this year may now prove over-optimistic - particularly for the years from 2011’. Monitor therefore required all FTs to submit revised plans with a “downside’ forecast’ for 2011/12 by the end of September 2009 which would take account of ‘a more pessimistic view on funding’³.

The recession will have a direct impact on nursing labour markets by altering supply and nurses’ labour market behaviour; indirectly it also will impact on demand for NHS nurses because NHS funding is constrained by fiscal tightening of public sector finances. The NHS is a labour intensive sector, and any significant changes in funding flows inevitably impact on staffing, in terms of numbers, new demand, and productivity issues.

Recent press speculation and ‘leaked’ reports have suggested that foundation trust plans could lead to the cut of 16,500 nursing jobs⁴, and that overall there could be a cut of one in ten NHS jobs. The latter figure, from a report invited, but not commissioned, by the Department of Health in England focused on achieving reductions through recruitment freezes and early retirement initiatives, including for community nurses, but its overall approach and conclusion has been dismissed by government ministers.⁵ It does, however, provide one extreme assessment of the potential scale of recession-driven staffing change over the next few years. And frontline NHS nurses are reportedly already noting evidence of budget trimming through reduced use of agency staff for cover, and recruitment freezes⁶.

The recession is the current critical factor external to the NHS which will impact on nursing labour markets and workforce policy. There are also other internal factors relating to policy initiatives and policy change.

The Nursing and Midwifery Council (NMC) announced in September 2008 that nursing would become an all graduate entry profession by the earlier part of next decade⁷. Nursing in England is now moving towards an all graduate entry route (already a factor in Wales), and this has major implications for education commissioning, workforce planning, and the skill mix of the profession. We discuss this in more detail in the final chapter.

Other current policy commitments and policies will also have an impact on the size and shape of the nursing and midwifery workforce. In England in 2008, the Secretary of State for Health announced a package of measures to support SHAs' plans to recruit an extra 4,000 midwives to the NHS by September 2012⁸, and in 2009 the Prime Minister's Commission on the Future of Nursing and Midwifery was established⁹. It is currently working to identify the competencies, skills and support that "frontline nurses and midwives need to take a central role in the design and delivery of 21st century services". There has also been an increased focus on frontline NHS staff wellbeing in England, with commitments in the NHS Constitution to clear roles, relevant training and staff engagement, whilst a separate review of staff wellbeing, has set out a number of recommendations including the need for board commitment, top management leadership and staff engagement¹⁰.

The other three UK countries have also been revising their approach to nurse workforce policy and planning. After a report from the Health, Wellbeing and Local Government Committee, Wales has recently committed itself to an integrated workforce planning approach with an emphasis on planning at health economy level¹¹. The Scottish Government Health Department has recently established a new Health Workforce Programme Board which will focus across all staff groups with the aim of a coordinated approach to workforce planning. It has also highlighted that an expected 'bulge' of graduates from Modernising Medical Careers will lead to 'oversupply in nearly all specialties', with subsequent planned reductions in the number of junior doctors from 2010 onwards, and related implications for nursing roles¹².

In Northern Ireland, health sector reform¹³ and the Review of Public Administration (RPA) have implications for workforce planning as the former 19 trusts have become six, while the Department of Health will retain national level workforce planning responsibility. A review of the NHS nursing workforce in Northern Ireland has recently been completed¹⁴ which noted reductions in pre-registration places, a review of attrition (based on newly agreed attrition data), and continuing concerns about availability of information on staffing in the independent sector.

Across the UK the Modernising Nursing Careers (MNC) initiative could change career pathways for nurses, and in its report earlier this year, the Review Body stressed the need for evidence to inform its deliberations on pay recommendations for health service professionals, including nurses: 'It is our view that the availability of robust, timely data on our remit group is critical to our ability to make informed, evidence-based decisions on pay and other matters... We note in Chapter 2 the progress the parties have made in providing us with better data, but we consider that gaps still exist..... Having access to accurate and timely information on the conclusions of workforce planning exercises is essential for us to fulfil our function. Specifically, we would like to be kept informed of forecast shortages or surpluses of particular categories of staff within our remit group, the Health Departments' strategies for addressing them, and the effectiveness of those strategies in helping to predict and manage shortages and surpluses of individual groups'¹⁵.

The NHS Workforce Review Team has also stressed recently that 'there is little data on the higher specialist nurse workforce. SHAs should emphasise the importance of fully completing the existing data fields within the Electronic Staff Record (ESR) to improve data quality on this workforce and assist effective workforce planning'¹⁶.

How well prepared is the NHS to deal with these challenges? In England, the most striking feature of post NSR (Next Stage Review) reform on workforce planning and policy ¹⁷ is that it is far from complete and the country runs the risk of yet another example of top down reform failing to align with changing workforce priorities and constraints. There has been progress on some aspects of the NSR, such as setting up the new Medical Education England (MEE), but others are delayed. The equivalent professional advisory mechanisms for nurses and other non-medical health professionals is not yet complete (the Department of Health has reported these should be established by December 2009); the Centre for Workforce Intelligence (CWI), which the NSR advocated should be established by April 2009 is not yet functioning (short listed bids are due to be tendered by late October 2009 so it is unlikely that the CWI will be functioning fully until well into 2010); and the local PCT and regional workforce planning architecture is not complete, in part because of limited capacity, in part because of continued lack of clarity about respective roles of different agencies.

One of our key messages in this year's report is the need to maintain an objective long term view on workforce policy and planning, during a time of short term economic pressures. There have been previous examples, discussed in this report, where short term financial expediency has undermined nurse workforce planning in the NHS, and has contributed to creating future skills shortages. The point about planning is that it should plan beyond short term factors, whilst taking account of their longer term implications.

In this regard we note the overall need to improve workforce productivity; the imminent establishment of a CWI in the NHS in England; the ongoing need throughout the UK to inform the Review Body about labour market trends, and the current focus on the nursing and midwifery in the context of the Prime Minister's Commission on Nursing and Midwifery. We raise significant concerns about the critically inadequate and worsening information base on which UK nursing workforce policy is formulated. In essence we question if there can be a fully effective policy response to the critical challenges facing the NHS nursing workforce on the basis of the currently available information, systems and data.

In recent years the LMR has documented the decline in availability of the data sets required to plan the nursing workforce effectively and to assess the impact of policies. This trend has not yet reversed. With the exception of the Electronic Staff Record (ESR) data being analysed by the Information Centre – which should improve the assessment of nurse job moves, absence etc. – there is little sign of improvement in the availability of necessary data on the nursing workforce, indeed there are signs of continuing paucity (see Box 1 below). These gaps and weaknesses are not insurmountable. In combination, effective use of the ESR data, structured involvement of non-NHS employers, development of the professionals register as a source of planning data, improved data on student intakes and systematic collection of attrition data would go a long way to improving the information base to a point where it can support effective policy making - at a time when such policy-making will be critical.

Box 1: Data to inform nursing workforce policy: what we have...what we need

What we need to know:	The reality:	What could be done:
1) Comparable UK wide attrition rates for pre-registration nursing and midwifery education.	Critical for effective commissioning and planning but there is currently no UK-wide complete and comparable data.	1) Establish UK-wide group of key stakeholders to agree common national UK wide definition of attrition. Implement, collate and publish annually
2) How many newly qualified nurses and midwives take up employment in the NHS or elsewhere.	Also critical for commissioning and planning. Was made more problematic because of changes in student indexing	1) Review decision and consider reintroducing indexing. 2) Tracer study of newly qualified nurses to assess first destination and career intentions.
3) Retirement behaviour of nurses.	Issue of vital and growing importance, particularly in community care, practice nursing and nursing homes sector given that so many are in the 50 plus age group.	1) Monitor retirement rates by age band, speciality and employment sector 2) Survey retirement plans of 50 plus aged nurses
4) How many of the overseas registrants are actually working in the UK, or where they are based. Data suggests recent marked increase in outflow of nurses from UK.	NHS in England does not record how many international nurses it employs. No accurate information on outflow of nurses from the UK. NMC published registration data is often out of date, and gives only basic overview of numerical flows.	1) NHS to introduce recording of source country of international nurses 2) Review of verification data and qualifications of nurses leaving UK register to assess actual trends in outflow and potential skills loss.
5) Cross border flows of nurses between the four UK countries.	A basic data element in a devolved country, yet not collected consistently or systematically. This is likely to become a growing issue with devolved government and diverging health policies in the four countries.	1) 'Joiners and leavers' data collection could include code for moves to/from other UK countries.
6) How many re-entrants stay working in the NHS after refresher training, where they are working, and the hours they work.	Assessing trends in returners an important element in overall planning. Return to practice data no longer collated at national level in	1) Public funded refresher courses should include mandatory end of course tracking

	England. Office of Manpower Economics (OME) survey has reducing response rate	2) Demographic and qualification profile of returners to register should be assessed.
7) Consistent and complete information on vacancy rates across the four UK countries.	Increasingly questions are being asked about relevance of 'point in time' three month vacancy rate, its accuracy and utility as a measure of shortage.	1) Standardise definition of vacancy; implement consistent monitoring of all and long term (three month plus) vacancies.
8) Flows of joiners and leavers in the NHS to assess the current sources of recruits and destinations of nurses leaving the NHS.	The one area of improvement, Information Centre analysis of ESR data, gives scope for new information, including use of stability rates. The other source, the OME survey, has reducing response rate.	1) Standardise definition of joiners and leavers; publish annually by organisation; publish year on year stability rates.
9) The dimensions of the growing non-NHS nursing labour market and the flow of nurses between the NHS and other nursing employment.	Vital for effective planning and commissioning at SHA level in a 'mixed economy' of providers, yet non-NHS data has worsened. Data currently not published nationally in England. This should be a core requirement for effective commissioning and planning in NHS England.	1) Establish UK-wide stakeholder group to agree collection, collation of key UK wide nursing workforce statistics; first priority to expand registration data so that it covers employment data.
10) 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. NMC does not publish data.	1) NMC to accelerate collation and publication of ethnicity data; assessment of reasons for current non response; focus marketing/publicity on need to obtain full information.

The remainder of this year's LMR is in three further sections:

- Chapter 2 reports on the current nursing workforce
- Chapter 3 assesses what we know about future supply of new nurses
- Chapter 4 concludes by identifying the current critical priorities for nurse workforce policy and planning.

2. The current UK nursing workforce

How many nurses?

In March 2008 there were 676,547 qualified nurses, midwives and health visitors registered with the Nursing and Midwifery Council (NMC). This represented a decline of 10,000 on the previous year – the first such fall in recent years. 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 coverage, quality and completeness in recent years – at a time when there is growing recognition of the need to capture effectively non-NHS employment trends and to involve non-NHS employers in workforce planning.

Data on the NHS nursing workforce cannot easily be aggregated up to UK level because of differences in definitions and collection methods in the four UK countries. Using the most recently published comparable NHS 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 1998-2008 (see 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, 1998 to 2008, four UK countries (September)

[Note: Scottish data is not directly comparable over time]

	1998	2008	%Change 1998 - 2008
England	247,238	315,410	28
<i>Scotland</i>	<i>35,245</i>	<i>41,453</i>	<i>18</i>
Wales	17,278	21,426	24
Northern Ireland	11,247	13,941	24

Sources: England: non medical staff census, The Information Centre, NHS. Northern Ireland – DHSSPSNI; data is for March; Scotland data - ISD Workforce Statistics; Wales –StatsWales. Note: percent figures are rounded.

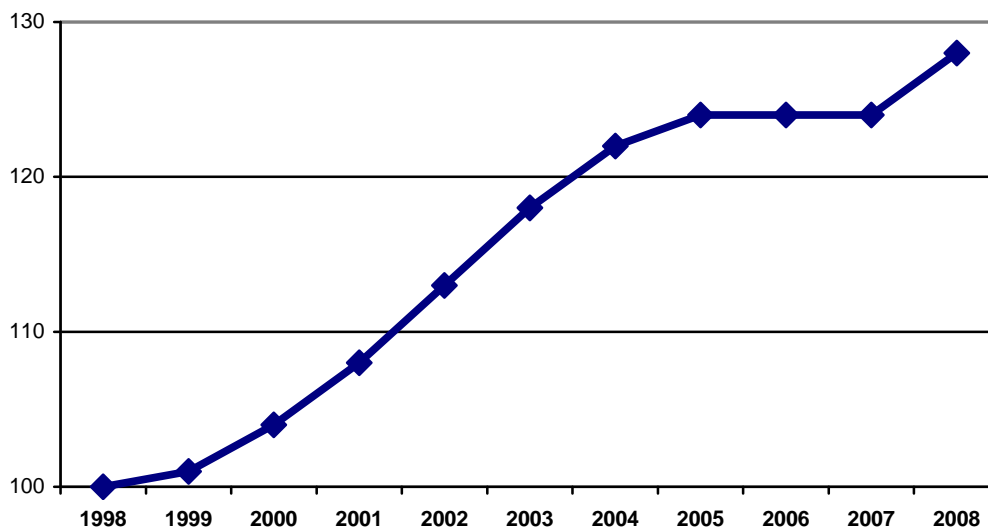
NOTE: Data for England includes bank nurses; data for other three countries does not. Scotland data for 2008 is not directly comparable with that from 1998 as data

collection was re-calibrated using Agenda for Change bands – 2008 data is for bands 5-9.

The UK countries all reported significant staffing growth over this period. This headline percentage increase in the four UK countries reflects government investment in funding more nurse education places; implementation of policies to improve retention and returners, and (mainly in England) a commitment to a policy of active international recruitment up to 2006.

However staffing growth has not been consistent across the period. It is clear from Figure 1 below that the growth in numbers tailed off between 2004 and 2007. There has been an apparent upward 'spike' in whole time equivalent numbers between 2007 and 2008, which included a doubling in one year of the numbers of modern matrons and community matrons. The actual numbers of health visitors and district nurses have declined in the same twelve months period.

Figure 1: England: NHS Qualified Nursing Workforce- % growth, 1998=100



Source: Information Centre

In terms of recent changes in reported whole time equivalent staffing levels, there has been a varied picture across the four UK countries. Year on year change should be treated with some caution due to changes in designation of some staff on assimilation to Agenda for Change. In contrast to the staffing growth reported in England between

2007 and 2008, Northern Ireland reported a much smaller increase in the period March 2007-2008 and subsequently continued low level growth to 2009¹⁸. In Scotland there was significant growth in band 5-9 nurses and midwives between 2007 and 2008¹⁹ whilst Wales reported an actual decline in qualified nurse staffing of 0.9% in 2007-2008²⁰.

The end of growth?

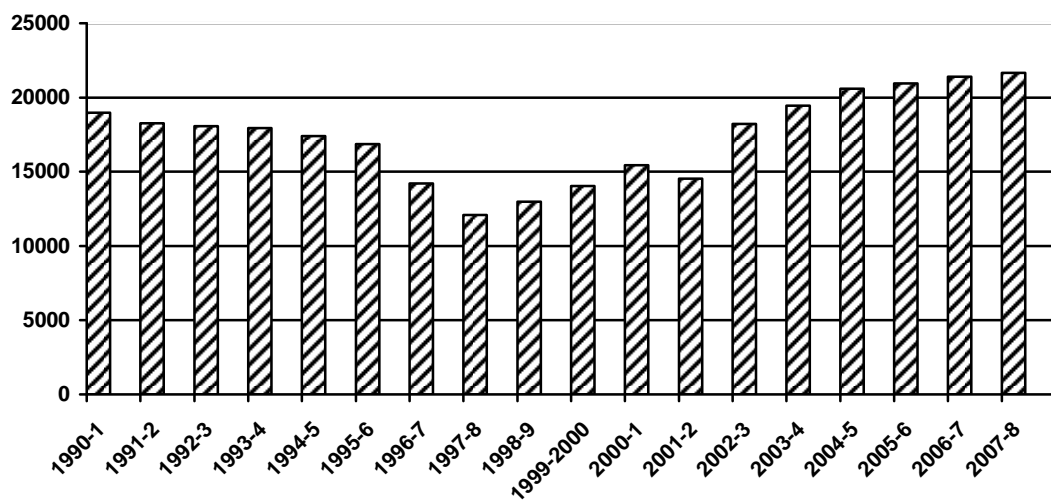
Most pre-registration nurse education in the UK is funded by government and the governments in the UK invested in pre-registration education of nurses and midwives as part of the overall approach to increasing the workforce in the late 1990s. This came after a period of marked decline in funding for nurse education places in the early 1990s. The clear message is that policy makers determine how many nurses are being trained in the UK through allocation of funding. There are always more applicants for nurse education than there are funded training places so numbers entering UK pre-registration education in the UK and subsequently entering the UK register are not a random or uncontrolled event, they are the outcome of funding decisions.

The pattern of decline and growth is shown in Figure 2. 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 1997/98, the direct result of funding decisions to reduce the number of pre-registration places on offer, despite clear evidence from scenario planning that this number was too low to meet future demand²¹. The consequent drop in UK entrants was predictable, given decisions to reduce funding for pre-registration places.

The self imposed nursing shortage of the mid/ late 1990s had to be addressed by a combination of increased UK training and active international recruitment. There was a significant upward trend between 1997/98 and 2007/08 as increased funding for pre-registration places led subsequently to more 'new' nurses coming out of pre-registration education in the UK. The new intake from UK education exceeded 20,000 in 2004/05 and 21,600 in 2007/08. England accounted for four out of every five new UK based entrants to the UK register in 2007/8.

There is a lag of several years between decisions on funding levels for pre-registration nurse education and these ‘new’ nurses entering the register. It should therefore be noted that reductions in commissioning in England in 2005/06 are likely to play through to training output declines from 2009. A later section of this report gives more detailed consideration to current patterns of intakes to pre-registration nurse education in the UK.

Figure 2: Number of new entrants to the UK nursing register from UK sources, 1990/1 to 2007/8



Source: NMC/UKCC

As noted earlier, the number of nurses and midwives on the NMC register declined by 10,000 between 2007 and 2008. In part this was accounted for by a reduction in the number of new initial registrations (mainly as a result of a marked drop in international nurses) but also because of a marked increase in the numbers leaving the register, choosing not to practice, or to retire²². Future supply side factors point to increased numbers of nurses reaching retirement age. This year’s assessment by the NHS Workforce Review Team notes the issue of growing numbers of nurses nearing retirement age and notes that ‘employers need to focus on retaining their current workforce through initiatives such as flexible retirement. International recruitment could also be used to increase nursing supply’²³.

Closing the door to international recruitment

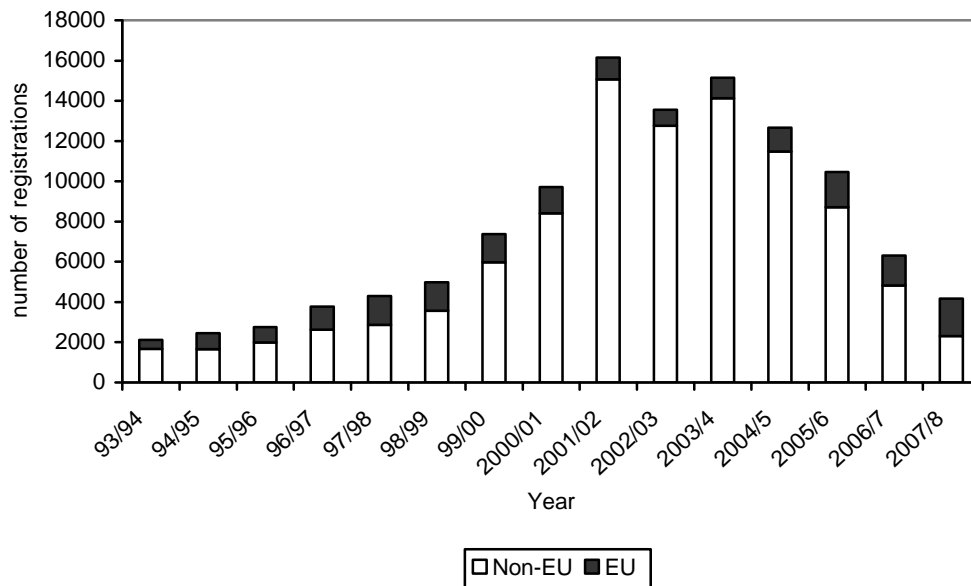
In the period between the late 1990s and middle of this decade, the UK, particularly England, was actively recruiting nurses from a number of countries. International recruitment of nurses can be attractive to policy makers because it enables rapid recruitment without the expense and lead in time required for commissioning more home based training of nurses.

However using international recruitment has become much more challenging for UK employers in recent years. This is not because there are fewer potential recruits. It is because a series of self imposed policy changes have made it much more difficult for non-EU nurses to enter the UK. Firstly, in 2005 the NMC instigated a much tougher (and costlier) programme for overseas nurses intending to practise in the UK. Secondly, in 2006 the main entry clinical grades in the NHS were removed from the Home Office shortage occupation list. Thirdly, in 2007 the NMC then also raised the English language test requirements. Finally, in 2008 the shift to a points based work permit system has reinforced the government policy of making international recruitment a more difficult option for employers, currently only some specialities of experienced nurses, such as critical care and theatre nursing are likely to qualify for entry. In recent months the RCN and other bodies such as the Registered Nursing Homes Association have been lobbying the Migration Advisory Committee (MAC) for the restrictions on international recruitment of non-EU nurses to be eased, arguing that it is contributing to nursing shortages in some sectors and specialities²⁴.

The Workforce Review Team in its 2009 assessment highlighted that ‘some areas of nursing remain difficult to recruit to; for example, intelligence indicates that nursing homes in particular have significant international recruitment to fill vacancies; and nursing roles in theatres and critical care units are often difficult to recruit to. Recruitment initiatives may be required to fill the immediate vacancies for senior posts and specialties that have been hard to recruit to historically (e.g. theatre nursing)’²⁵.

The collapse in international recruitment is starkly obvious. NMC data gives some sense of the massive pendulum swing in the number of international nurses registering to practise in the UK. In a ten year period the UK has shifted from low level international recruitment activity in the late 1990s to very high levels of recruitment in the early part of this decade, back down to low activity in recent years. (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).

Figure 3 : Admissions to the UK nursing register from EU countries and other (non EU) countries 1993/94 - 2007/8

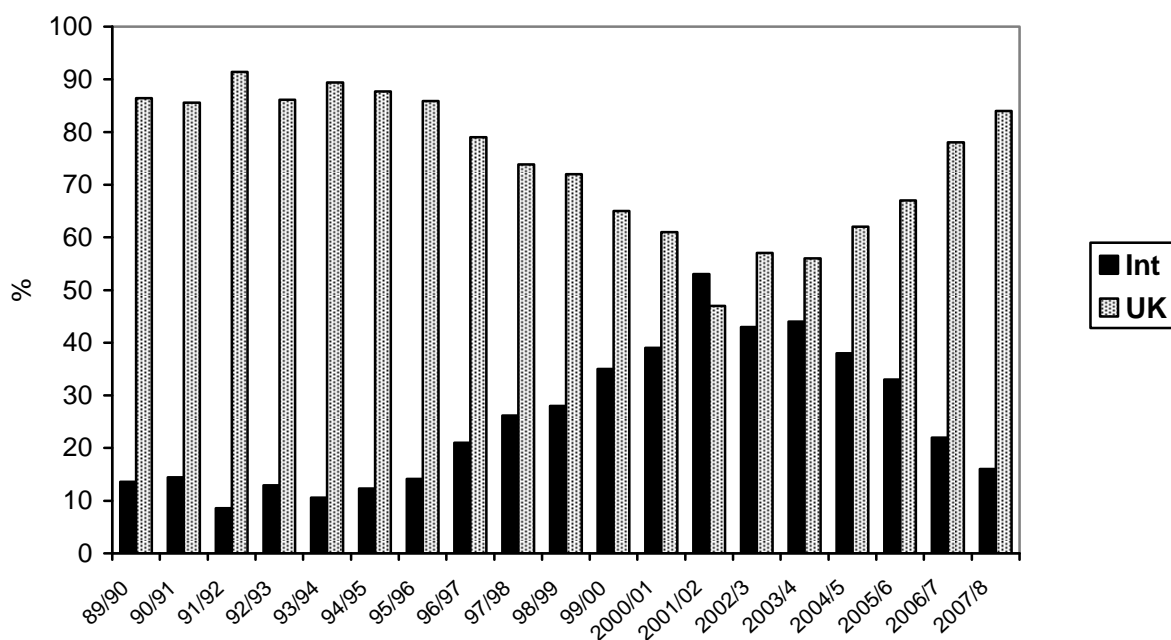


Source: NMC/UKCC

In 2002, more than 16,000 international nurses were registered; in 2007-8, just 4,000. The overall marked decline in international nurses has also masked another important trend that the UK is now proportionately more much more reliant on nurses registering from the EU. In 2007-8, more nurses registered from Poland or Romania than did from traditional source countries such as Australia, and more nurses registered from Bulgaria, Germany and Italy than from New Zealand. EU nurses are not subject to the same constraints on entry to the UK as are nurses from other countries, and this is a factor in this relative switch in the pattern of source countries. Overall, there is currently a historically low level of entry of nurses to the UK.

The drop in international recruitment of nurses to the UK in recent years is highlighted in Figure 4, which shows the relative contribution of UK and of overseas sources to ‘new’ nurse registrations since 1989/90. In the early 1990s, overseas countries were the source of about one in ten nurses entering the UK register. The overseas contribution rose rapidly in the late 1990s, both in terms of numbers and as a percentage of total new entrants, peaking in 2001/02 when more than half the new registrants were from non UK sources. The decline in reliance on new international nurses since that year has been steep and continuous, and has now dropped to the level being reported in the early 1990s.

Figure 4: International and UK sources as a % of total new admissions to the UK nursing register, 1989/90 - 2007/8 (Initial Registrations)



Source: UKCC/NMC data

As noted earlier, one of the reasons that active international recruitment was so attractive to policy makers in the UK in the late 1990s was that it offered a quick fix. The nurses have been trained elsewhere, at someone else’s expense, and could 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. What has now happened is that self imposed changes to regulatory and general migration policy have contributed to a

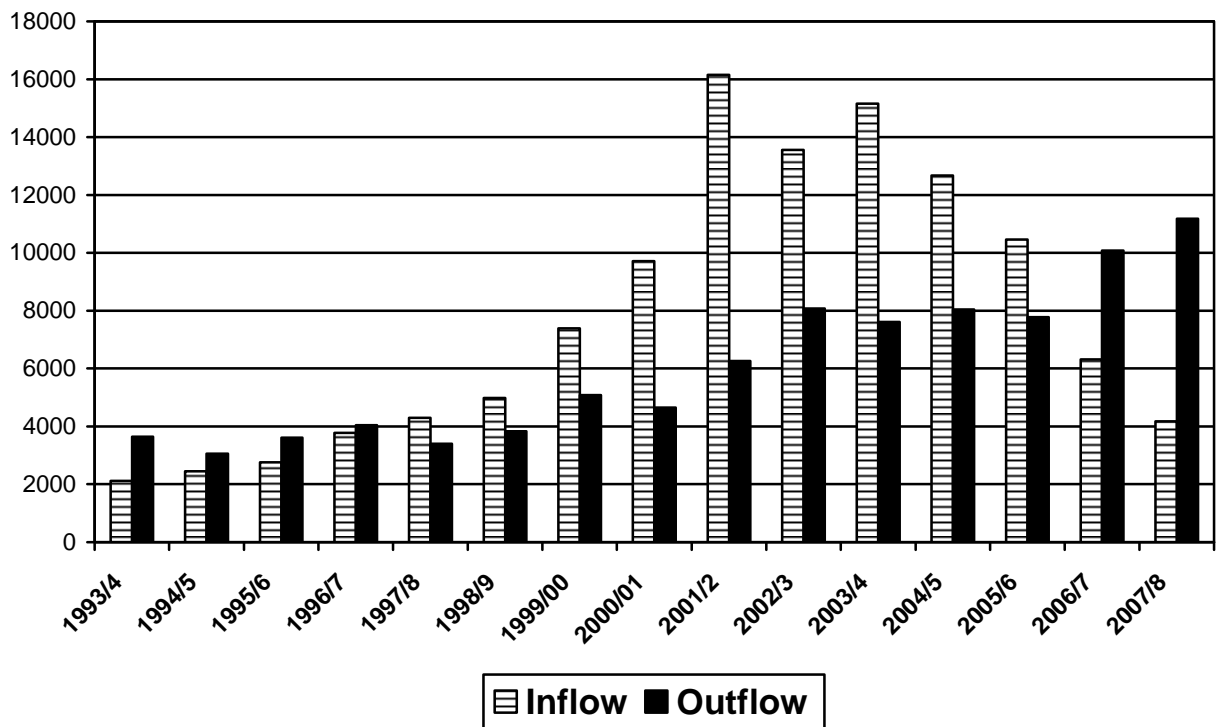
situation where the UK is moving from being an active recruiter of nurses to a passive 'source' of nurses for other countries..

The destination becomes a source

In 2007/8 more than 11,000 UK registered nurses requested their UK registration to be verified, as part of the process of applying for a job in another country¹. This was at the highest level in 20 years and continues a recent upward trend.

Figure 5 shows the trend in annual numbers of nurses applying for verification to nurse abroad ('outflow') alongside the numbers from other countries registering to practise in the UK ('inflow'). This gives an overall picture of the trends in flows to and from the UK. It is clear that the UK has shifted rapidly from being a net beneficiary of international flows in the early part of this decade to a situation in the last two years when there has been a marked net outflow of nurses.

Fig 5: 'Inflow' and 'Outflow' of nurses from the UK, 1993-2008

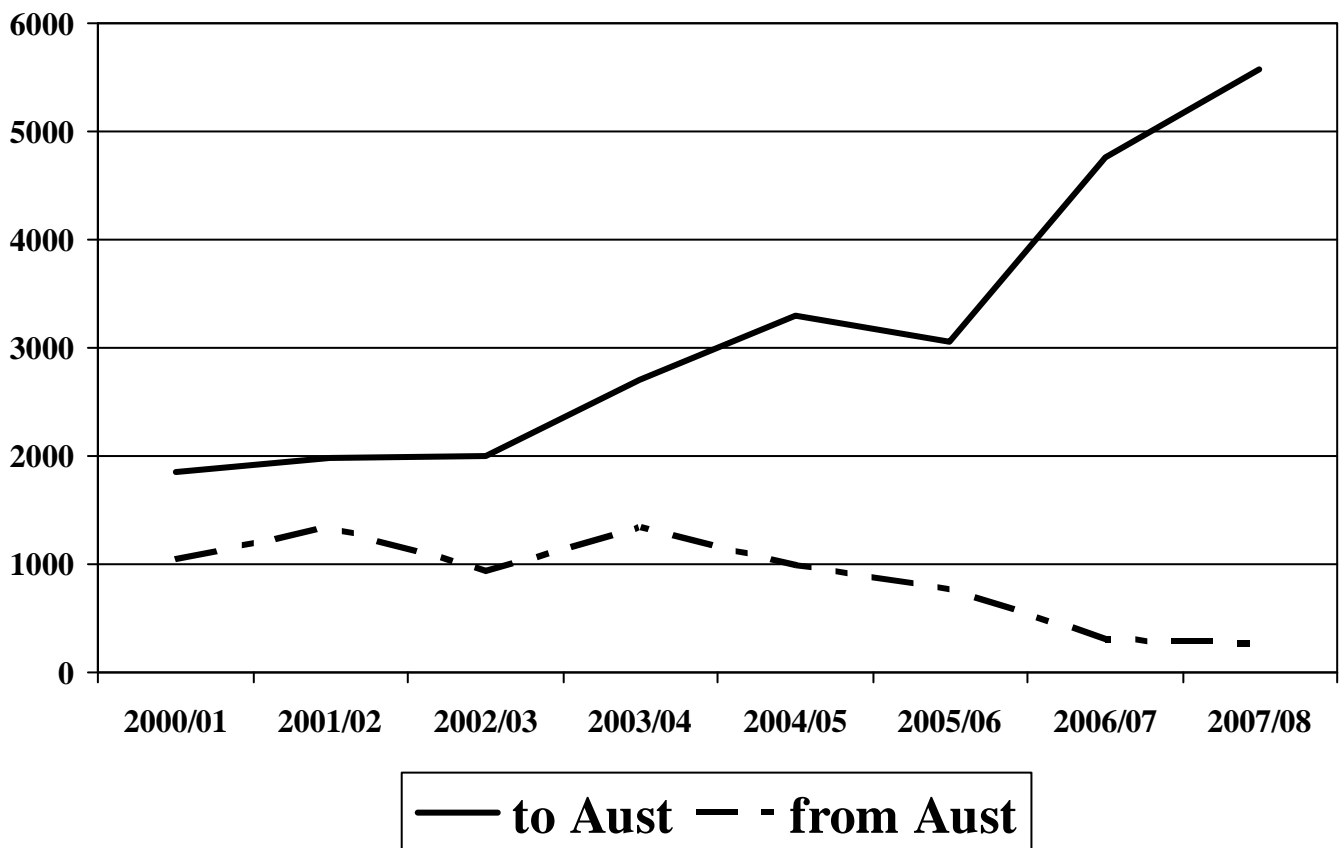


Source: NMC/UKCC

¹ This NMC data indicates an intention to nurse in other countries; it does not necessarily record an actual geographical move.

Half of all the verification requests from UK based nurses in 2007/8 were for just one destination country: Australia. The Australian economy has suffered less from the global economic crises than most developed countries, has in recent years been projecting significant nursing shortages, and is now investing in increasing its health workforce- both by increasing home based training, and by active international recruitment. It is planning a new agency to co-ordinate planning and recruitment- reportedly with a first year budget of 18 \$Aus million for international recruitment of nurses and doctors²⁶. The UK appears to be one of its targets (see Fig 6).

Fig 6: UK nurses applying to move to Australia; Australia nurses first regisitering in the UK: 2000-2008



Source: NMC

Figure 6 marks an increasingly unbalanced net flow of nurses to Australia from the UK. In 2000-1, approximately 1,000 Australian nurses registered in the UK and about twice that number of verifications were issued for nurses from the UK to practise in Australia. Seven years later in 2008, less than 300 Australian nurses

registered in the UK whilst more than 5,500 verifications were issued to practise in Australia.

The next few years...

The Workforce Review Team has recently published its annual assessment of NHS workforce issues in England²⁷. It highlights the need for vigilance in keeping training intakes at necessary levels and sets out a range of ‘suggested mitigation strategies’ to improve recruitment, retention and deployment of nurses and midwives. These include ‘SHAs to consider increasing current commissioning levels in light of the latest WRT forecasts’; ‘employers to ensure that nurses have the appropriate clinical and leadership skills to deliver new ways of working’; ‘PCTs and employers to increase availability of community placements, including in nursing homes’; and ‘recruitment initiatives to encourage nurses to work in a primary care setting’.

As in 2008, the WRT comments that overall supply of the nursing workforce largely meets demand. Modelling conducted by WRT in 2008 forecast that if current commissions were maintained there would be a slight reduction in the number of nurses available in the future²⁸; the projections suggested a slight decline in overall NHS nursing numbers across the period 2007 to 2016. This assessment is not dissimilar to the results of scenario modelling undertaken for the RCN in 2007. This modelling suggested that the size of the NHS nursing workforce in England in 10 years’ time was vulnerable to the impact of varying policy interventions on retention, retirement and international recruitment, but would not exhibit the pace of growth of recent years, even under the most positive scenario, and could decline if the inflow from international recruitment remained low and retention of older nurses did not improve²⁹.

These projections were conducted before the full extent of the recession were known, and therefore do take into account any related labour market changes. They do however set out the ‘before recession’ scenario which made it clear that it was going to be difficult to maintain nursing numbers, because of ageing of the workforce and the collapse in international recruitment, and that much depended on ensuring that new intakes to pre-registration education were kept at an appropriate level. In the ‘after recession’ scenario, this underlying requirement across the mid-

long term does not change. In the next chapter we examine the most recent, if incomplete, data on new intakes.

3. The UK's future: supply from training and education

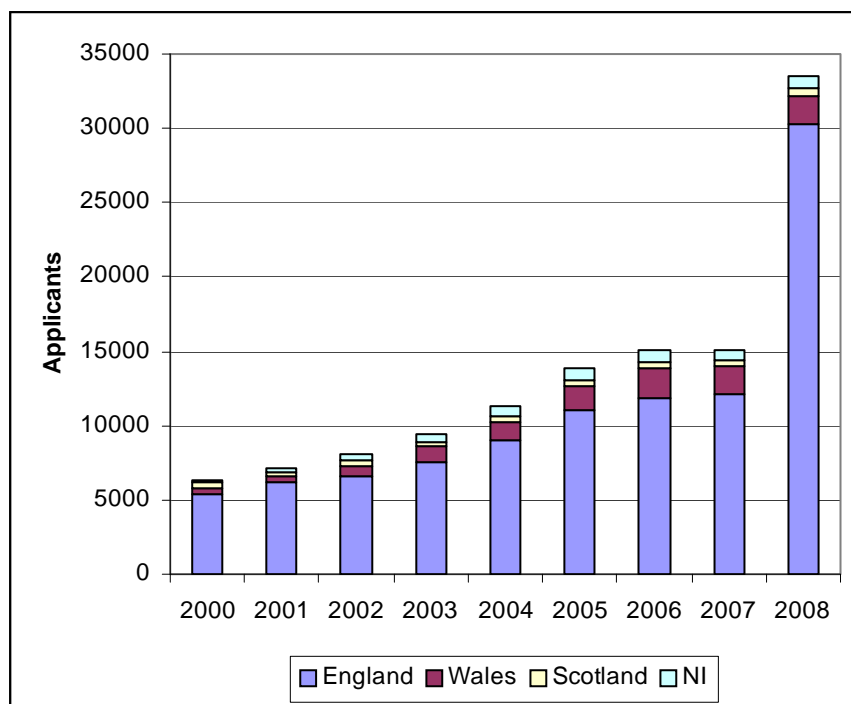
Attracting people into nursing careers is essential to maintain and develop the nursing workforce. Some research³⁰ has found that school age children are largely indifferent to nursing with comparatively few seeing it as a potential career choice. In this section we will look first at trends in numbers of applications to enter nursing education, then at the numbers of training places available. Finally we will try to establish how many nursing students there are and how many newly qualified nurses are likely to join the workforce over the next few years.

Taking up nursing education

The Nursing and Midwifery Council (NMC) announced in summer 2008 that the minimum award for UK pre-registration programmes leading to registration as a nurse will be a degree.³¹ A recent commentary concluded that nursing no longer attracts sufficient numbers of school leavers and that having limited qualifications would exclude almost a third of current entrants from degree programmes.³² Equally, however, it was suggested that degree level programmes could attract people who had previously rejected nursing because they would not get a degree or had not considered it as a career option.

To cope with rising demand nursing arguably needs to maintain a wide entry gate and to adapt strategies that tailor access accordingly. Ironically however, monitoring the numbers of applicants and changes in the composition of the applicant population has become more difficult. The Nursing and Midwifery Advisory Service (NMAS), which processed applications for full-length, diploma-level, pre-registration nursing and midwifery programmes at universities and colleges of higher education in England, ceased to operate in October 2007. All the pre-registration diploma courses in nursing and midwifery previously in the NMAS scheme have now been transferred to the UCAS application system. One consequence of this transfer is that more limited data are published on applicants and flows into nursing education and therefore underlying trends are difficult to discern. Figure 7 illustrates the problem and shows the numbers of applicants handled by UCAS country for each of the last nine years. The following paragraphs unpick these figures as far as we are able.

Figure 7: Number of applicants for pre-registration nursing courses processed via UCAS 2000-2008 by country



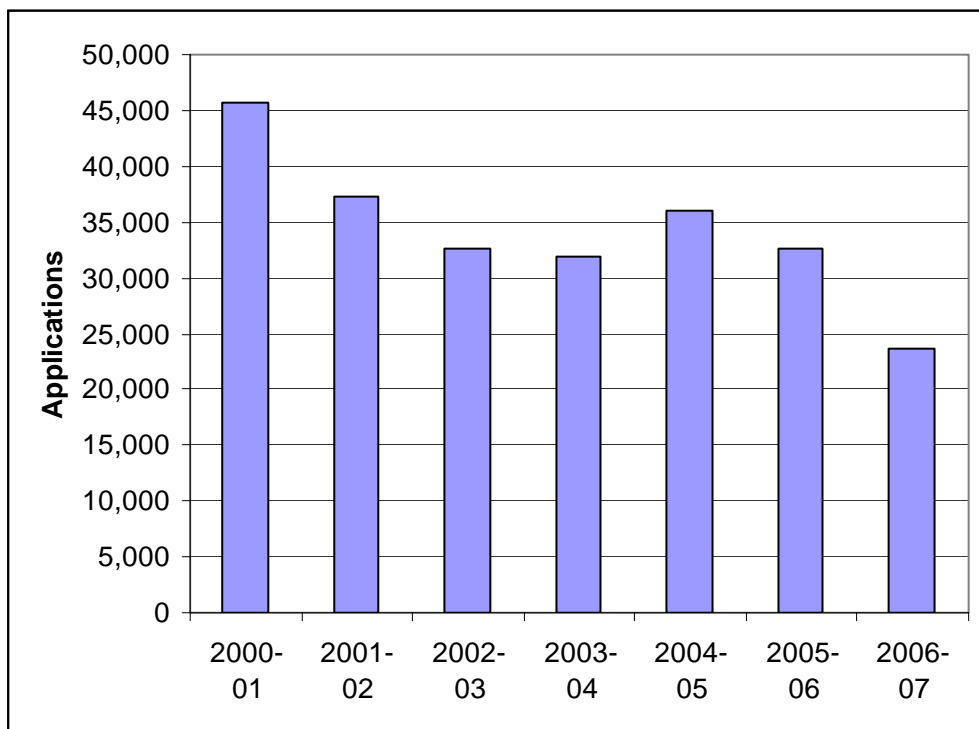
Source: UCAS

Figures on the numbers of applicants by country for 2009 will not be released for some time. However UK-wide statistics on the number of choices made by applicants are available and these show a substantial rise both in nursing degree choices (up 20.7% to 59,895) and nursing ‘other’ choices (up 17.5% to 50,155).³³ Figures released by UCAS at the end of August 2009 report increases in the numbers of acceptances for both degree courses (up 23.5% to 7,301) and diploma courses (up 20.4% to 13,139)³⁴.

England: prior to 2008 the applicant statistics for England could be divided into diploma and degree course applications. In 2007 UCAS received applications for degree level nursing and midwifery courses from 12,100 students in England while NMAS had applications from 23,722 for entry to diploma courses. Together then, there were approximately 35,800 applicants (assuming insignificant numbers applied for both degree and diploma level entry in the same cycle). Applications for degree level courses have risen steadily from just over 5,000 in 2000, with growth slowing from 2005 onwards. That growth is outweighed by the fall in applications for diploma

courses which were at their lowest recorded level (23,722) in 2006-07 (figure 8). In 2008 UCAS reported that they received applications from 30,296 students for the 2008 entry. However, figures for 2009 entry released by UCAS for the UK as a whole (data at the level of country is not yet available) indicate that the numbers of applications have increased and it is likely that a substantial proportion of that increase will be in England.³⁵

Figure 8: England: trend in applications for diploma level pre-registration nursing and midwifery programmes, 2000-01 to 2006-07



Source: NMAS

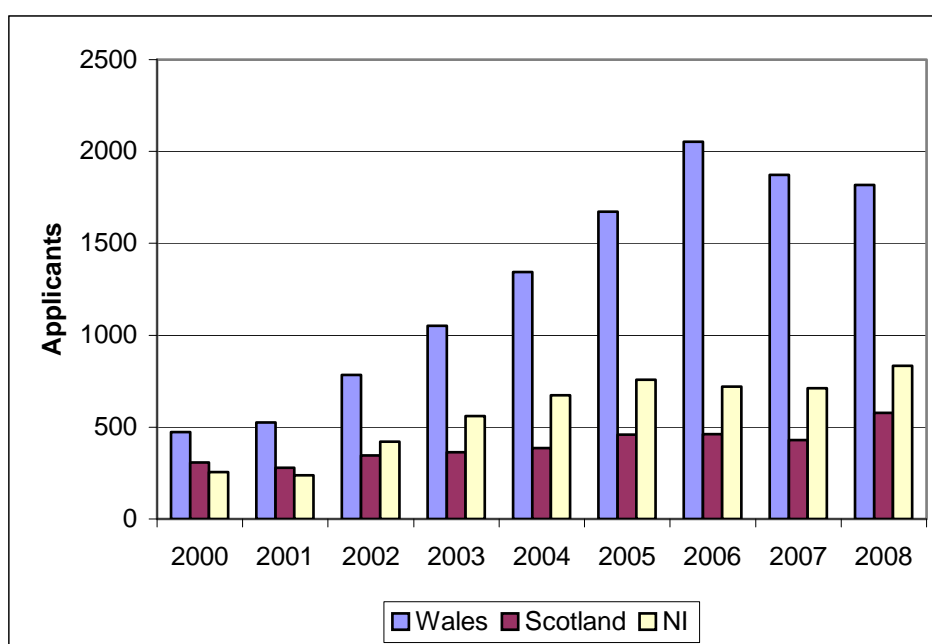
Equally important though are the figures on how many applicants are successful. The numbers of applicants who are successful in securing a diploma course place has fallen much more slowly. From a peak of 16,771 in 2004-05 this fell to 12,763 in 2006-07. Figures on the number of successful degree course applicants at country level are only available for the past four years. These show an increase roughly in proportion to the increasing number of applicants. That is, acceptances rise from 4,651 in 2005 to 5,071 in 2007, an increase of 9% (applicant numbers increased by 10% over this period). In 2008 UCAS figures show that there were 19,859 successful applicants for diploma and degree course places in England, roughly two-thirds of all

applicants. This compares with the previous three years when, on average, two-fifths of applicants for degree course places were successful. Although, 2009 data are not yet available at country level, the all-UK data recently released by UCAS implies an increase in acceptances onto both degree and diploma courses in England³⁶.

Scotland, Wales and Northern Ireland

Trends in applicant numbers in Scotland, Wales and Northern Ireland are difficult to detect from figure 7 because of the scale of applicant numbers in England. Figure 9 shows applicant numbers for these three countries separately.

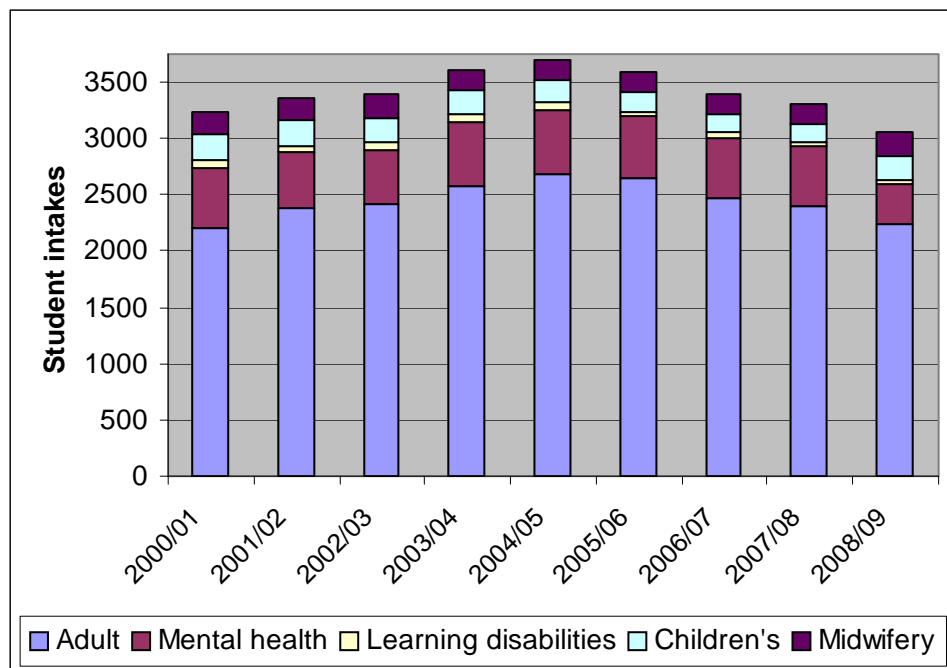
Figure 9: Scotland, Wales and Northern Ireland: numbers of applicants handled by UCAS 2000-2008



Source: UCAS

In Scotland, intakes to pre-registration courses (figure 10) have continued to fall from their peak (3,698) in 2004/05 with data for 2008/09 showing the biggest one year fall (8%) to 3,060.

Figure 10: Scotland: numbers of students starting 3-year nursing and midwifery programmes, 2000/01 to 2008/09



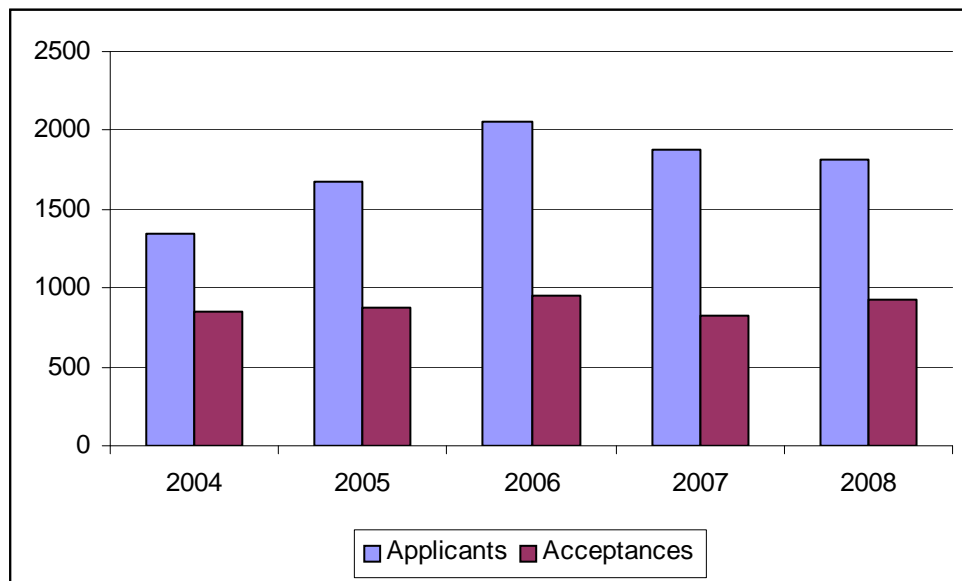
Source: ISD

Substantial reductions in intakes to the adult and mental health branches account for the overall decline despite increased intakes in learning disabilities, children's nursing and midwifery.

Figures from UCAS show that the numbers of applicants for degree level nursing and midwifery education in Scotland declined to 431 in 2007 compared with 461 in 2006. Acceptances also fell (to 216) although the ratio of applicants to acceptances remained at roughly 2:1. In 2008 however there were a record 569 applicants for entry in 2008. Whether this increase (32%) is real or partly an artefact from the closure of the NMAS processing system remains to be seen. Acceptances rose to 304 (a 'success' rate of 53%).

In Wales all pre-registration nursing education has been at university degree level for some time. Available figures from UCAS show that the number of applicants for entry to degree level courses rose from 1,343 in 2004 to a peak of 2,052 in 2006 before dropping back to 1,874 in 2007 and 1,819 in 2008. Acceptances have however continued to increase, growing from 828 in 2007 to 924 in 2008 (Figure 11).

Figure 11: Wales: applicants and acceptances for degree level pre-registration education, 2004 to 2008



Source: UCAS

Northern Ireland figures from UCAS shows that the number of applicants to degree level courses has fallen from a peak of 758 in 2005 to 712 in 2007, with 405 acceptances. The combined figure for 2008 was 832 of whom 541 were accepted.

Unpicking this evidence is not straightforward because of changes in the reporting and differences between applications, applicants and acceptances. The emerging picture suggests that in recent years the overall numbers of applicants for pre-registration nursing education courses has reduced, with contrasting trends in degree (increasing) and diploma (reducing) courses. However, the latest figures suggest that overall applications, and acceptances, are now rising.

Staying in nursing education

The number of nursing students and midwives who withdraw from pre-registration education without completing their course is an important consideration in determining the future supply of qualified staff. Robust up-to date figures remain elusive despite attempts to improve the collection and reliability of data. In the absence of official data the *Nursing Standard* used the Freedom of Information Act to request attrition data from all institutions across the UK that taught nursing courses

between 2002 and 2006. The figures reveal that out of 25,101 nursing students, who began degrees or diplomas, a total of 6,603 did not complete their courses. This gives an overall attrition rate of 26.3%, somewhat higher than the 20% used in planning assumptions for England by the Department of Health. At the time of writing a similar exercise to collect data for more recent student cohorts is underway.

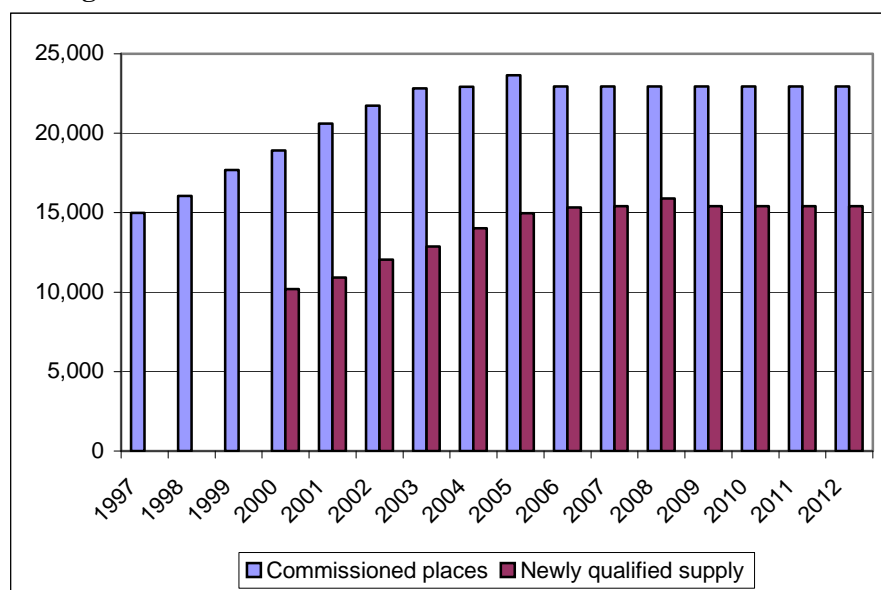
How many nursing education places are there?

In addition to student aspirations and choices, a key determinant of the numbers entering pre-registration nursing education is affordability and specifically the numbers of places being commissioned.

In England, the NHS Workforce Review Team last forecast pre-registration commissioning levels (to 2012) in October 2007. These forecasts were based on assumptions about growth in the nursing workforce, attrition from training and participation rates of newly qualified nurses. They anticipate a peak in output from training of 15,893 in 2008 and a constant output of 15,416 each year thereafter. The level of commissions required to generate these outputs was calculated as 22,941 per year (figure 12). In practice, actual commissions over the past three years have been lower than this at 20,314 in 2005/06, 21,199 in 2006/07 and 19,352 in 2007/08.³⁷ The overall reduction in the number of commissions will (in the absence of any significant change in attrition levels) result in fewer newly qualified nurses coming into the labour supply from 2009 onwards and a shortfall against the projected requirements published by the WRT.

WRT report that SHA commissioning intentions for 2009/10 show that ‘...a number of ...’ SHAs have decided to increase the number of nursing places at HEIs in response to recommendations made in the Assessment of Workforce Priorities 2008. Whether this amounts to a net increase in commissioned places nationally is unclear. The WRT’s Assessment of Workforce Priorities 2009 concludes that: ‘SHAs should plan in the context of actual commissions historically being lower than planned commissions’.

Figure 12: England: planned commissions and expected output for pre-registration nursing 1997 to 2012

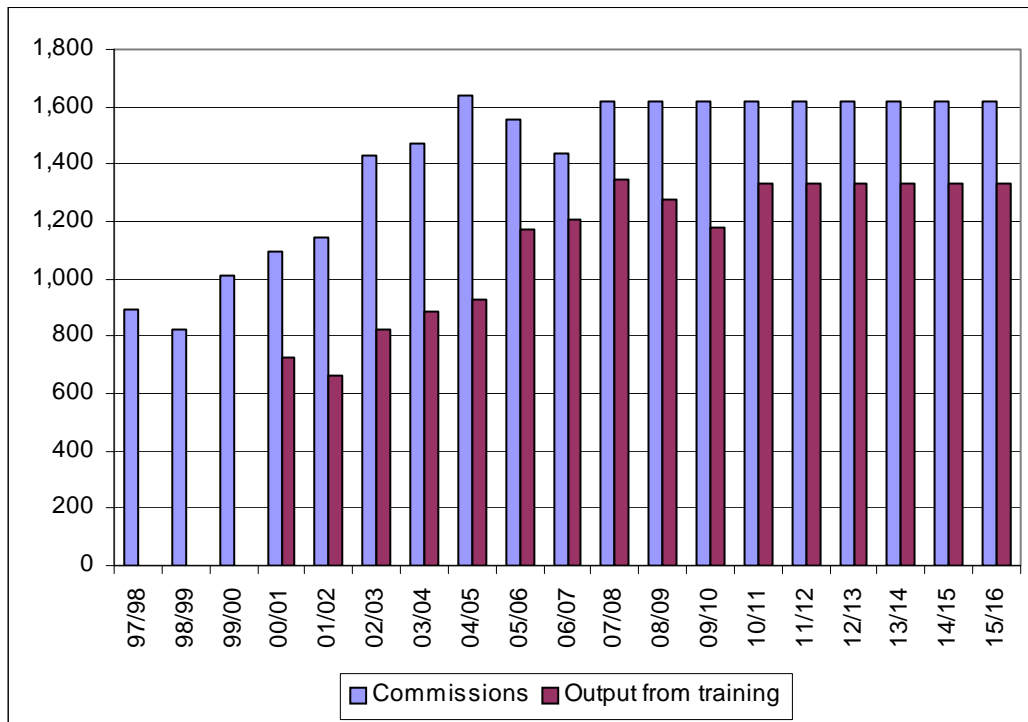


Source: based on WRT nursing proforma 2007

As noted in the first chapter, in February 2008 the Secretary of State for Health announced a package of measures to support plans to recruit an extra 4,000 midwives to the NHS in England by September 2012. Prior to this midwifery commissions were forecast (figure 13) as growing to 1,622 a year from 2008 with an expected output of 1,481 per year. Figures published by WRT show that, at 1,990, actual commissions in 2006/07 were higher than the model forecast and planned commissions for 2007/08 were reported as 2,116. A new forecast reflecting the expected increase in staffing levels has not yet been made available but in September 2009 the WRT report that all SHAs have responded positively to the 2008 announcement by increasing midwifery degree commissions in 2008/09. They also emphasise that SHAs ‘... should focus on reducing attrition rates from 3 year and 18 month midwifery courses.’

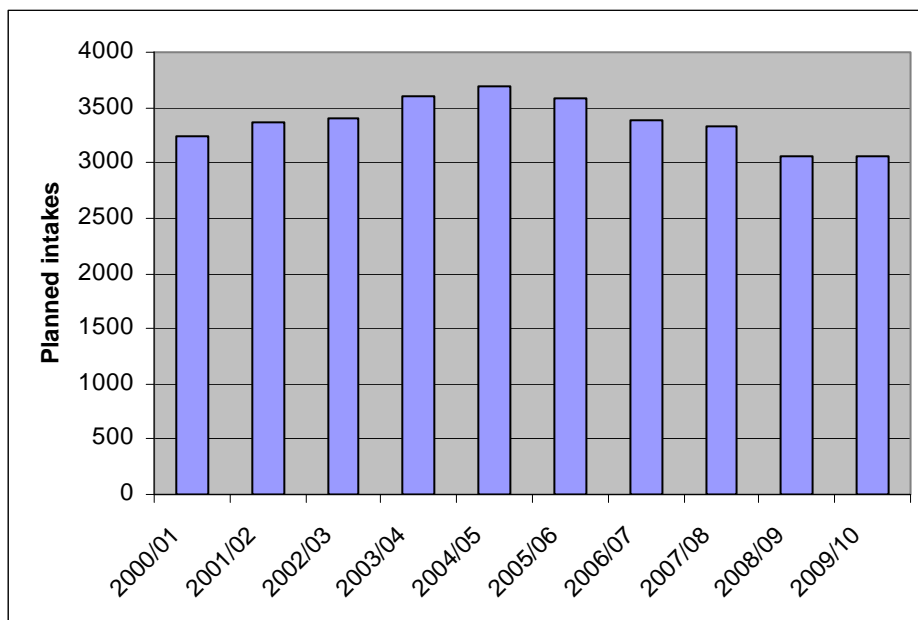
In Scotland the Nursing and Midwifery Workforce Planning Process (formerly known as Student Nurse Intake Planning – SNIP) recommended overall stability in intakes to training for 2009/10. That is, the numbers are to be kept at 3,060 but with some shift by branch: increased intakes in mental health (up from 340 to 404) and learning disabilities (up from 50 to 60) compensated by reductions in adult (down from 2247 to 2211), and midwifery (from 220 to 182).³⁸ Figure 14 shows the intake recommendations from SNIP/NMWP from 2000/01 to 2009/010.

Figure 13: England: planned commissions and expected output for pre-registration midwifery 1997/98 to 2015/16



Source: based on WRT midwifery proforma 2007

Figure 14: Intake recommendations for pre-registration nursing and midwifery in Scotland, 2000/01 to 2009/10



Source: NHSScotland

In Wales the new integrated workforce planning process for NHS Wales was launched in 2008. This required health economies to submit commissioning requirements in the autumn. In February 2009 the health minister announced a 15% increase in midwifery training places (from 95 to 110) a 30% increase in mental health places (from 130 to 170) and a 2% increase in community nursing degree places (from 134 to 137).³⁹ Information about other branches of nursing has not been published.

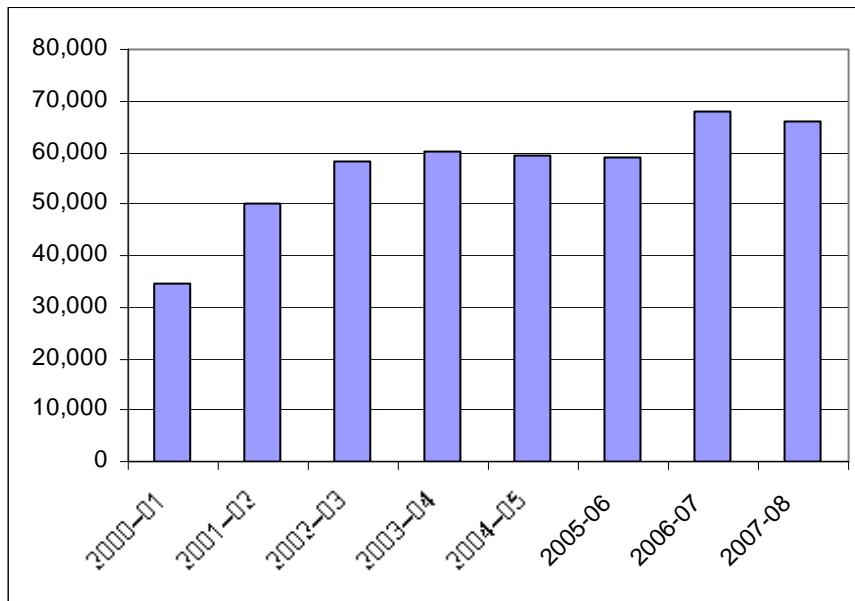
In Northern Ireland the Department of Health, Social Services and Public Safety carried out a comprehensive review of the nursing, midwifery and health visiting workforce in 2005. The review identified specific recruitment and retention issues and made projections of the supply and demand for the five year period 2005-2009. Following a budget cut in 2005, the number of places was reduced by 20 and now stands at 730 pre-registration nursing places per annum. The number of midwifery (three year and 18 month courses) places commissioned has increased from 44 in 2005 and 2006 to 50 in 2007.⁴⁰ A further review was undertaken in 2008 but remains unpublished at the time of writing.

How many students are there?

The most recently published figures from the Higher Education Statistics Agency show that, at the end of July 2008, there were 82,540 students on full-time (more than 24 weeks) 'undergraduate' nursing courses in higher education institutions across the UK, some 7 per cent fewer than in the previous year. However, these figures do not separately identify pre-registration nursing and midwifery education from other, post-registration, courses nor do they distinguish between the four countries. Best estimates of the current population in training on pre-registration nursing courses by country are:

- **England:** the numbers of pre-registration nursing students in receipt of non-means tested NHS bursaries in England provides the best clue to the size of the student population. However these figures have not been published since 2007-08 when they showed approximately 66,000 pre-registration nursing and 4,645 midwifery students. Allowing for attrition and reduction in numbers of commissioned places, the current total is likely to be marginally lower than this.

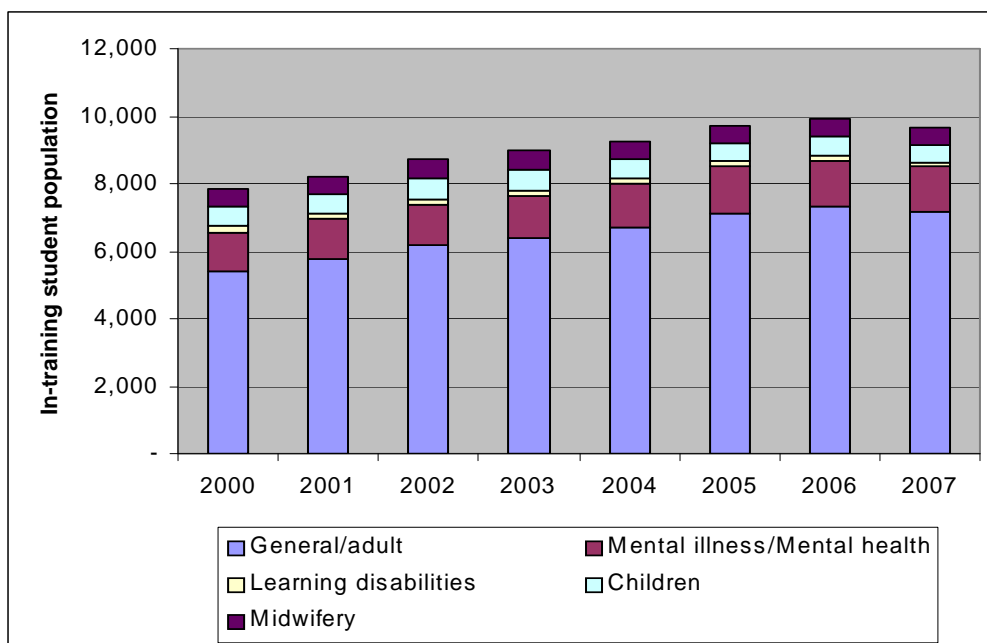
Figure 15: Numbers of pre-registration nursing students with NHS bursaries 2000-01 to 2007-08



Source: House of Commons, Hansard

- Scotland:** latest available figures are for end March 2007 and show a fall to 9,660 in the number of first level nursing and midwifery students in Scottish Higher Education Institutions (paid for centrally). This represents a fall of 2.5% (249) since March 2006 and is smaller even than the 2005 intake. Numbers enrolled in midwifery show the only increase (by 21 or 4%).

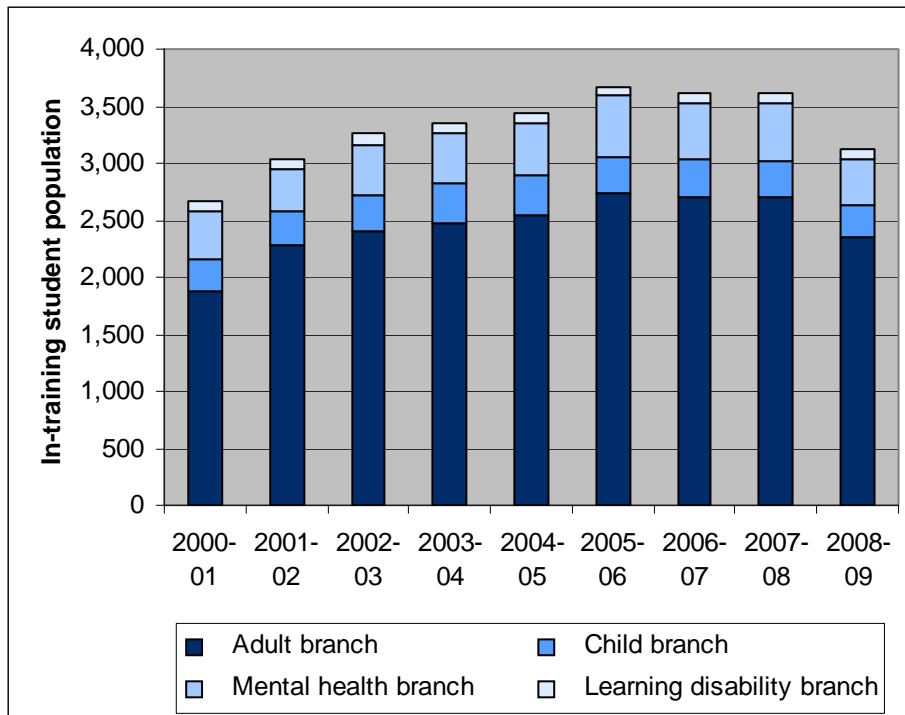
Figure 16: Scotland: population of pre-registration nursing and midwifery students, 2000 to 2007 by branch



Source: ISD, NHS Scotland Workforce Statistics

- **Wales:** latest data (April 2009) show 3,126 in training an overall drop of 13.5%, with mental health falling 19%; the only significant increase being in pre-registration midwifery.⁴¹

Figure 17: Wales: population of pre-registration nursing students by branch, 2000/01 to 2008/09



Source: Health Statistics Wales

- **Northern Ireland:** no recent figures are available. Approximately 2,187 full-time undergraduate nursing students were enrolled on courses at Queens University Belfast, University of Ulster and the Open University in 2006/07.⁴²

In summary, this chapter has shown that, arguably, we know less about the most critical nursing labour market flows – into and out of education – than ever before, and that the overall evidence we can piece together suggests that the numbers of pre-registration places available and intakes to them have been reducing in recent years, with some variation by country and branch. However, the latest figures indicate that the numbers of applicants, and the numbers of acceptances, have both risen for 2009. Intakes have usually been smaller, and attrition rates higher than workforce planners expected. Consequently fewer newly qualified nurses will

enter the UK nursing labour market over the next few years than has been planned.

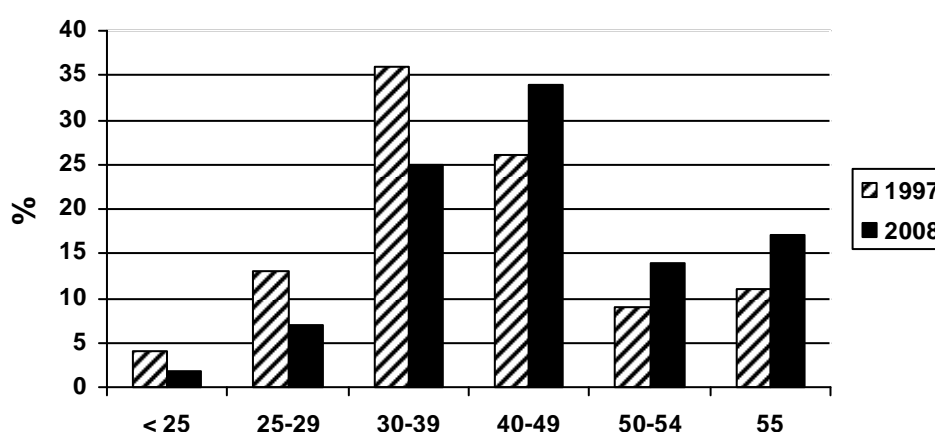
4. Maintaining the long view: addressing the real priorities that face the nursing workforce

Against a backdrop of critical NHS funding, there are three key nursing workforce challenges that can be identified with total certainty. The first is entirely predictable and cannot be avoided, but will be impacted by recession, i.e., the ageing of the NHS nursing workforce. The second is a policy priority but may be severely undermined by the impact of NHS funding constraints - the shift from acute to community/primary care. The third is the planning and policy implications of all graduate nursing, and the related issue of the development of the use of the assistant practitioner.

Dealing with the ageing of the workforce

The UK registered nursing population, as with many others in the developed world, is ageing. In 2008 less than one in ten was aged under 30, whilst one in three was aged 50 or older. Figure 18 shows the shift of the age profile of nurses on the UK register over the twelve year period 1997-2008. More than 200,000 nurses on the register were aged 50 or older in 2008.

Figure 18 : Age profile, UK Nursing Register 1997 and 2008



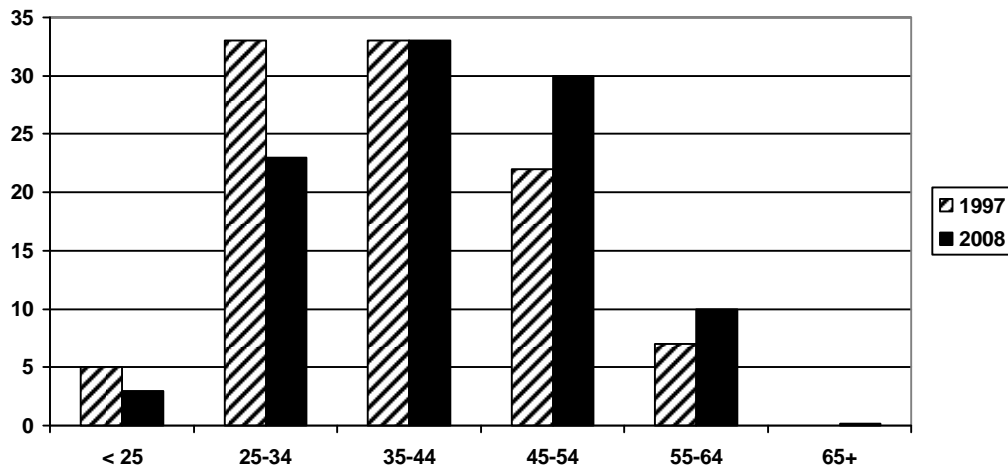
Source: NMC

The impact of recession may delay the retirement of some nurses, and attract others back into the labour market. Even so, larger cohorts aged 50 plus are moving into retirement age over the next few years. Those older nurses who continue to

participate in employment are less likely to work full-time, if past trends are continued, which may mean a relative reduction in nursing hours available from those who do delay retirement. The RCN membership surveys have shown consistently that the proportion of nurses working full-time falls in older age groups.

Paralleling the ageing of nurses on the Register, there has been a marked ageing in the NHS nursing workforce (Figure 19), partly a result of the reductions in nursing student intakes in the early/ mid 1990s, and partly as a result of the emphasis on attracting returners. The increase in average age of nursing students will also have contributed to this ageing profile.

Figure 19: Age profile of NHS qualified nurses, England, 1997 and 2008

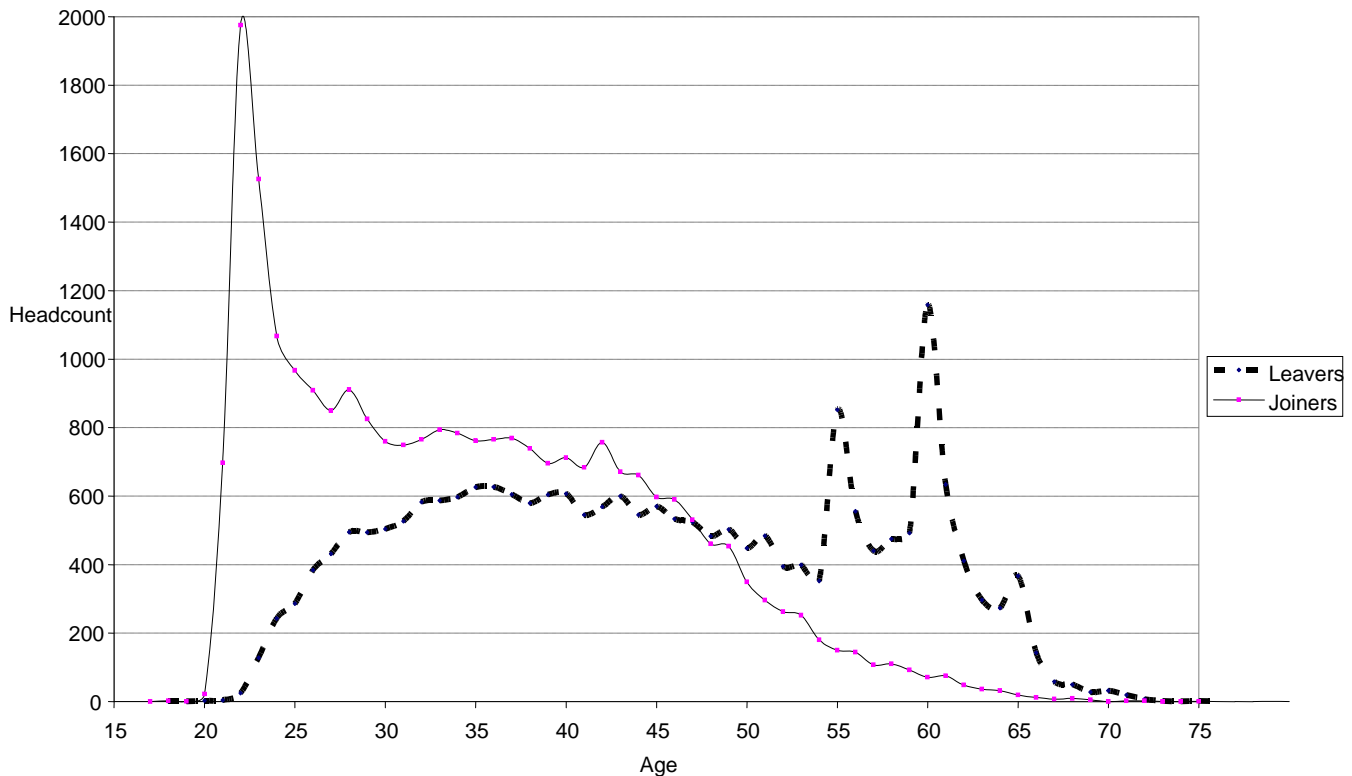


Source: Department of Health/ The Information Centre, NHS

Note: excludes those for whom age was unknown

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 (or any employment - registrants may maintain registration but not be in employment); and the older age profile of nurses working in some of the non-NHS sectors, particularly nursing homes and practice nursing.

Fig 20: NHS England: Qualified Nurse leavers from 2007, joiners in 2008 age distribution



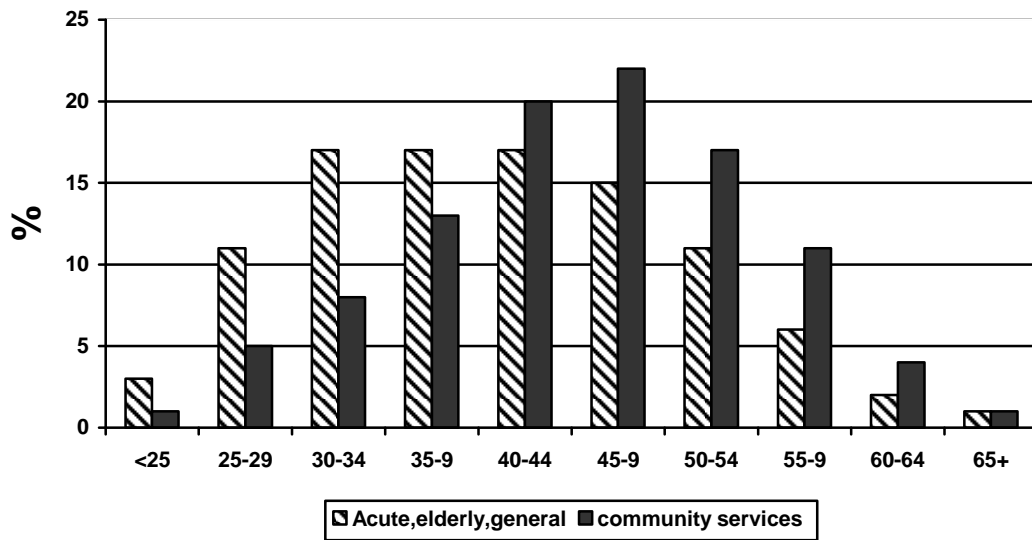
Source: Information Centre

Data on NHS nurses in England (Fig 20) highlights that age 55 and 60 are currently peak times for ‘leavers’ from the workforce.

Nursing homes, practice nursing and NHS community nursing will be particularly vulnerable to the impact of ageing and retirement. Nurses working in NHS community nursing services 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 (Figure 21). This means that the impact of growing retirements will hit the community sector earlier and harder.

In 2008 the NHS Workforce Review Team reported that in NHS England ‘a disproportionate level of the current nursing workforce in primary care is expected to retire in the next 5-10 years: 21% of health visitors, 16% of school nurses and 17% of district nurses are aged over 55’⁴³. A similar pattern is seen in the other UK countries.

Figure 21: Age profile, NHS nurses- acute/care of elderly/general, and community services, England, Sept 2007



Source: Department of Health/ The Information Centre, NHS

One critical factor in determining the retirement behaviour of current nurses and in maintaining the long term attractiveness of the profession is pension provision. Against a background of increasing debate about the maintenance of final salary pensions in the public sector, there have been agreed changes to the pension scheme for nurses. From April 2008 there are now two separate schemes. One is the existing NHS pension scheme, with updated rules and benefits. It will continue to be a final salary scheme with a normal pension age of 60 (or 55 for special classes, for example some nurses with mental health officer status). This scheme is for current scheme members and for those who chose to join before 1 April 2008. The second 'new' NHS pension scheme is a new final salary scheme for anyone who joined on or after 1 April 2008. It will have a normal pension age of 65, a higher accrual rate and a different set of rules and benefits.

This current change in the scheme is likely to have only limited impact on retirement behaviour and patterns in the foreseeable future, as it means that NHS nursing staff in employment on or before 1 April 2008 will retain the right to retire at a normal retirement age of 60. NHS Pensions Choices the as yet incomplete new initiative for pension choice in England and Wales may also have an impact. It is clear however

that public sector pension provision is under scrutiny as part of the overall debate about public sector funding⁴⁴.

With about 200,000 NMC registrants aged 50 and older, one in three NHS community nurses being aged 50 plus, and almost one in five practice nurses being aged 55 plus, the challenge of meeting the need to replace those who retire or delay their retirement will become increasingly prominent over the next few years. There have been a series of policy research papers in recent years which have focused on the issue of the ageing nursing workforce^{45 46 47}. These papers have argued 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.

Care to community

There has been a policy focus in all four UK countries in recent years to shift resources, care delivery, and staff to community/ primary care and away from acute care. Generally the workforce planning and development issues related to this shift of focus have been given insufficient attention. Community nursing will carry a major responsibility for delivering any change and growth in this sector, yet, as highlighted above, the community nursing workforce is particularly vulnerable to the impact of ageing, and is also a sector that is currently relatively more highly dependent on part-time staff.

Several recent policy assessments have flagged scope for increased deployment of nurses in advanced roles in community/ primary care. One recent national assessment (in England) of the workforce implications of shifting care to community settings⁴⁸ reported that 'all those interviewed saw the development of the nurse practitioner as key. Nurse to doctor ratios would increase and the role of nurses would expand, with more specialist nurses', (p.13). The review concluded that the demand for primary care services is likely to grow substantially in the medium term, and that rising demand could be met in part by increasing use of practice nurses and other skill mix changes to make greater use of nurses (nurse practitioners) and allied health professionals. However, the review also noted that there was not a ready pool of

nurses for primary care; the practice nurse population was ageing and the capacity of the system to fast track newly qualified nurses into primary care was growing only slowly. Another review for the Scottish government⁴⁹ reported considerable scope for nurses to work in advanced roles in community care as part of supporting the shift in balance of care. Finally the workforce strategy for London⁵⁰ estimated in 2008 that 22% of nurses were based in a community setting and that this should increase to 40% within the next decade as well as a doubling in the number of advanced practitioners over the next 5-8 years and a 'potential 29%' growth in the number of assistant practitioners⁵¹.

Despite these policy objectives and compelling evidence base, there is little evidence as yet of any step change in the pattern of deployment of qualified nurses in favour of primary care. In 1998, 14% of qualified nurses, midwives and health visitors were recorded as working in "community services" in the NHS in England. After ten years of policy commitment to shifting care to the community, this figure had only improved by the smallest of margins. In 2008, 16% of qualified staff were reportedly working in community services⁵².

If the NHS wishes to follow through on its vision for a primary care led service it will have to take account of the retraining and redeployment needs of the current workforce. It is evident that there will have to be more investment in specialist bridging training for hospital based and other acute sector nurses who are interested in working in the community sector, and there will have to be further efforts to establish community oriented pre- and post-registration education courses to increase the supply pipeline. This will have to be achieved at a time of funding constraint, in which budgets for training, re-training and re-deployment are likely to be targeted for cost saving.

Graduate change

As noted earlier in this report, the diploma route is currently the major source of newly qualified nurses, but the UK is now committed to moving to all graduate entry- at different pace of change in the four UK countries, but now with a unified single objective. This move was based on education led arguments that nursing must become a graduate profession to meet the needs of complex care delivery in an increasingly

fast paced health care system which demands flexible, responsive and highly skilled practitioners

Moving to an all graduate route will have to be planned with consideration to levels of applicants, education capacity, and future mix of staff. The NHS Workforce Review Team has given notice that it will be examining the workforce implications of this change; earlier in this report we have highlighted that there are already marked changes in the level and composition of applications and entrants to pre- registration nurse education in the four UK countries. What will also have to be examined carefully is the impact of these changes on staffing mix and staffing levels.

There is a growing awareness that the all graduate model will ask questions about current mix, the future numbers of registered nurses, and the use of a new role- the assistant practitioner. NHS Employers noted recently that the move will bring challenges for workforce planning, and is likely to stimulate employers to look to make more use of assistant practitioners⁵³. They have argued for “clarity on the future workforce supply implications of moving to all degree education programmes. It has been stated that there will be fewer qualified practitioners but actual forecasts would help to focus minds on the actual task ahead and the infrastructure requirements to ensure services can continue.....”⁵⁴

In a different report NHS Employers have also stressed that “the step change from employing registered nurses and health care assistants to graduate nurses and assistant practitioners at Agenda for Change band 4 needs to be carefully assessed by employers”⁵⁵. About half of NHS trusts responding to a survey in 2007 reported that they had assistant practitioner roles with a relatively low level overall; but with plans for growth reported⁵⁶. Skills for Health have been conducting a scoping exercise of the role of assistant practitioners (APs) as part of a process to determine core standards (which are planned for publication in October 2009). The scoping exercise noted significant variation in the role of the AP, that APs were normally paid on band 4 of Agenda for Change and reported, ‘the overwhelming message we have found from all regions is very positive about the introduction of assistant practitioners’⁵⁷.

The drive to all graduate entry is therefore likely to be a major contributing factor to growth in the deployment of the new role of assistant practitioner. There is recent precedent for such skill mix changes. The most rapidly growing part of the broader NHS nursing workforce this decade has been health care assistants.

Conclusion

Nursing cannot and should not hope that economic recession will solve its labour market challenges. The key pressures discussed above may be ameliorated in the short term by the easing of supply side difficulties as more nursing hours become available, but they will not be ended. Recession also heralds funding constraint. At best, the unplanned short term labour market benefits of recession will provide a breathing space in which planners and policy makers can more effectively put in place longer term measures to address the underlying challenges of the ageing of the nursing workforce, the focus on community care, and the need to develop the right workforce profile to support an all graduate entry route.

These challenges will have to be met, irrespective of the level of constraint on NHS funding. And they will have to be met across a time period when Workforce Review Team and other projections have suggested that the underlying trend was for a potential reduction in NHS nursing numbers, due to ageing of the workforce, little evidence of any improvements in retention, and the collapse in international recruitment.

The risk of not maintaining this longer term strategic view, of letting short-termism drive training cuts and vacancy freezes, is that the supply side problems that have been identified in these projections will be exacerbated, as they were in the mid 1990s. The other impacts of unplanned and uncoordinated responses to the economic challenges facing the NHS would be more immediate, but no less damaging, if they adversely effect staffing levels and workload- and cut across the good intentions set out in the NHS Constitution.

There is growing recognition that the focus on staffing based cost containment in the NHS over the next few years brings with it a high risk of a negative impact on quality of care, and also that training budgets may be reduced or raided, as has happened in previous years. The NHS Confederation has flagged that ‘diluting quality’ and extending waiting times could be a consequence of the search for costs savings in the NHS and that the ‘loss of knowledge and experience’ linked to staff reductions ‘has hidden costs’⁵⁸. They also warn against ‘cutting training’, noting that ‘poorly thought

through cuts in training lead to avoidable shortages as finances recover and produce demand for additional staff⁵⁹.

This growing concern is counter-pointed by a growing evidence base on the links between well qualified nursing staff and improved patient, nurse and financial outcomes⁶⁰, and of the economic value of well qualified and effectively deployed nurses⁶¹. There is no doubt that the next few years will be the most difficult for decades for the planners and policy makers who have the responsibility to sustain an adequate, productive and motivated nursing workforce. As we have argued in this report, there is an urgent need to improve the workforce information required to make effective policy choices on these issues. Decisions on how to respond to fiscal constraint in the short term will determine the longer term viability of the nursing workforce.

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Publication code 003 554