

# An incomplete plan

The UK nursing labour  
market review 2008



Royal College  
of Nursing

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**The UK nursing labour market review 2008**

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## Summary

The shape and structure of NHS workforce planning in each of the four countries of the UK is changing, notably in England.

The *Next Stage Review* (NSR) report which sets out the new direction in England has not yet been fully detailed, but it reinforces two distinct processes – for “medical” and “non – medical” workforce planning. A policy shift towards more community based care is also evident in the four UK countries.

After rapid growth in the early part of the decade, NHS nursing numbers have flat-lined. NHS funding constraints have significantly reduced demand for new nurses compared to four or five years ago.

The Workforce Review Team (WRT) projections suggest a slight decline in overall NHS nursing numbers in England across the period 2007 to 2016.

There has been a marked decline in applications for diploma based nurse education, a decline in acceptances, and notable declines in male applicants and older applicants in England. Applications for degree based nurse education in England have continued to rise, but acceptances have dropped back in the most recent year. There have also been reported recent declines in intakes in Scotland, Wales and Northern Ireland.

The ageing of the nursing workforce will be a critical challenge in the next 10 years. About 200,000 nurses (30%) on the UK register are aged 50 and older, and survey evidence suggests that one in three NHS community nurses is aged 50 plus, and almost one in five practice nurses is aged 55 plus.

The attempt to shift care from the acute sector to primary care will be the second main challenge. An unpublished review by WRT of the workforce implications of shifting care to community settings suggested that the development of the nurse practitioner role will be key and that nurse to doctor ratios in community care would increase, with an expansion in the role of nurses.

The NHS London workforce strategy argues that whilst 22% of nurses are currently based in a community setting, this will increase to 40% within the next decade.

Growing the primary care nursing workforce is not just a simple matter of recruiting direct from the acute sector or direct from UK training. The skills base required to work in the community is different. There will have to be more investment in specialist bridging training for hospital based nurses, and there will have to be further efforts to establish community oriented education courses to increase the supply pipeline.

The nurse workforce information base is weak, fragmented and eroding. Any new structure for NHS nurse workforce planning is likely to fail if there is no improvement in the current incomplete information on which it is based.

## **1. New structures, old problems**

This report is the 2008 review of the UK nursing labour market (LMR) commissioned by the Royal College of Nursing. It is two years since the last LMR was published, and in that time much has changed. The 2006 report highlighted 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.

In this first chapter of the review we consider current approaches to workforce planning. In the second chapter we review recent trends in the nursing workforce, identify key drivers for change, and give consideration to likely trends over the next few years. In the third chapter we report on the next generation of nurses – those currently in pre-registration education, and trends in commissioning in the four UK countries. In the final chapter we conclude by identifying the two critical challenges which face NHS nursing – the ageing of the workforce, and the shift to community care – and discuss how these can be met.

The shape and structure of NHS workforce planning in each of the four countries of the UK has changed, to a greater or lesser extent in recent years. The most notable changes have been in England. In 2007 the Health Committee of the House of Commons published a report on NHS Workforce Planning<sup>1</sup>. This was the first time they had focused on the issue in eight years. (The previous report of the Health Committee: *Future NHS staffing requirements* was published in February 1999, and many of its recommendations were accepted by government, which set out a plan for improving workforce planning in *A health service of all the talents* a year later, in April 2000). The Health Committee's objectives in 2007 were to assess how effectively NHS workforce planning had been undertaken and how it should be done in the future.

The report of the committee characterised the government's handling of NHS workforce planning as a 'disastrous failure' and pointed to a lack of strategic planning by the Department of Health. They also argued that there was insufficient workforce planning capacity within the NHS and were critical of the impact of restructuring on workforce planning and policy making. Poor integration and co-ordination between workforce and financial planning were also cited.

The report concluded that there was evidence that the NHS in England has gone from "boom to bust". In order to produce a workforce appropriate for the future, the report made one major recommendation: "workforce planning must be a priority for the health service. We do not

support further restructuring. It matters less who does the job than it is done well and taken seriously”.

The Department of Health in England made a preliminary response to the Health Committee report in 2007; however it was otherwise heavily involved in managing the high profile implementation problems of the new medical training and career structure, with the associated intense media activity. The Tooke Inquiry<sup>2</sup> was set up to review and make recommendations on the issue of medical education and career structure as a result of these difficulties.

One of the key criticisms of the Health Committee was that NHS workforce planning in England had not been in alignment with service and financial planning. An opportunity to achieve such an alignment came with the Darzi led Next Stage Review (NSR) which signals a policy shift to primary / community based care<sup>3</sup>. Similar shifts are also happening in the other UK countries, for example, in Scotland the NHS is piloting a new service model for community nursing, including the development of a new community health nurse role<sup>4</sup>.

One key strand of the NSR is a report setting out the future direction of workforce planning and development in England<sup>5</sup>. For nursing in England, it also highlights a move towards an all graduate entry route (already a factor in Wales), which will have major implications for education commissioning, workforce planning, and the skill mix of the profession. As discussed later in this report, the diploma route is currently the major source of newly qualified nurses. The Nursing and Midwifery Council (NMC) has recently ratified proposals which could make nursing an all graduate entry profession by 2015<sup>6</sup>. 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 NSR workforce report sets out a vision of a “bottom up” approach to NHS workforce planning and commissioning, a system that should be “focused on quality; patient centred; clinically driven; flexible; locally led and clear about roles” (para 101, p.31). It scopes out a range of new responsibilities and changed roles for the different stakeholders in the planning and commissioning process. At a national level a new “Centre of Excellence” is to be set up to collate, synthesise and analyse strategic health authority (SHA) plans, scan the horizon to gather intelligence for workforce planning and provide an evidence based analytical function for workforce modelling and labour market analysis (para 119, p.36). Also at a national level, and building on the Tooke recommendations, another new body, Medical Education for England (MEE) will provide a professional voice in the planning, education and training

process for medical staff, dentists, health care scientists and pharmacists. [At the time of writing there is ongoing debate about a nursing representation at national level in a professional advisory board but it is unclear what role would be played by such a board]. Scotland already has a national level multi-professional body – NHS Education for Scotland. The Department of Health will commission medical and dental undergraduates and will retain a role in “long term strategic workforce planning and policy development”. By default, nurse workforce planning is flagged to be a concern mainly at regional/local level.

The NSR workforce report can be viewed in part as a response to the Tooke inquiry; it gives more attention and consideration to the mechanisms of medical workforce planning and commissioning than to the other professional groups, notably nursing. As such, it can be argued that the NSR and Tooke signal the end of the move (or aspiration) for fully integrated workforce planning in which the planning processes for the different professions were to be fully consolidated – in favour of separate but aligned approaches – with much of the focus in nursing being at SHA and local level. As such the NSR report has served to reinforce two distinct processes: for medical and non-medical workforce planning.

The NSR’s detailed proposals on the revised planning and funding arrangements are not yet fully developed. The Department of Health reports a range of detailed reviews to be available in November 2008<sup>7</sup>. At the time of writing there remain unresolved tensions about the relative power and influence of primary care trusts (PCTs), NHS trusts and SHAs<sup>8</sup> in the workforce planning process with some commentators advocating an approach that is more explicitly employer led<sup>9</sup>, and the role of the Centre of Excellence has yet to be mapped out.

The other three UK countries have also been revising their approach to nurse workforce planning, but to varying and lesser degrees of change than England. 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 level<sup>10</sup>. Both Wales and the current NHS workforce plan in Scotland<sup>11</sup> put a lot of emphasis on the alignment of workforce planning with service planning and funding streams. In Scotland there is also work ongoing to develop purpose built workload assessment tools for different nursing specialities. Northern Ireland is currently going through health sector reform<sup>12</sup>. The Review of Public Administration (RPA) will 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 completed<sup>13</sup> 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.

The LMR is in three further sections:

Chapter 2 reports on the current nursing workforce

Chapter 3 reports on what we know about future supply of new nurses

Chapter 4 concludes by identifying the current critical priorities for nurse workforce planning.

## 2. The current UK nursing workforce

### Full-tilt to flat-line

In March 2007 there were 688,886 qualified nurses, midwives and health visitors registered with the NMC. Growth has tailed off 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. The urgent need to improve data on non NHS employment sources will be discussed later in the report.

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 1997-2007 (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 % change in the NHS qualified nursing and midwifery workforce, 1997 to 2007, four UK countries (September) (Data for Scotland is 2006).**

	1997	2007	%Change 1997 - 2007
<b>England</b>	246,011	307,628	<b>25</b>
<b>Scotland</b>	35,245	41,004	<b>17</b> <i>(2006)</i>
<b>Wales</b>	17,228	21,443	<b>24</b>
<b>Northern Ireland</b>	11,508	13,345	<b>16</b>

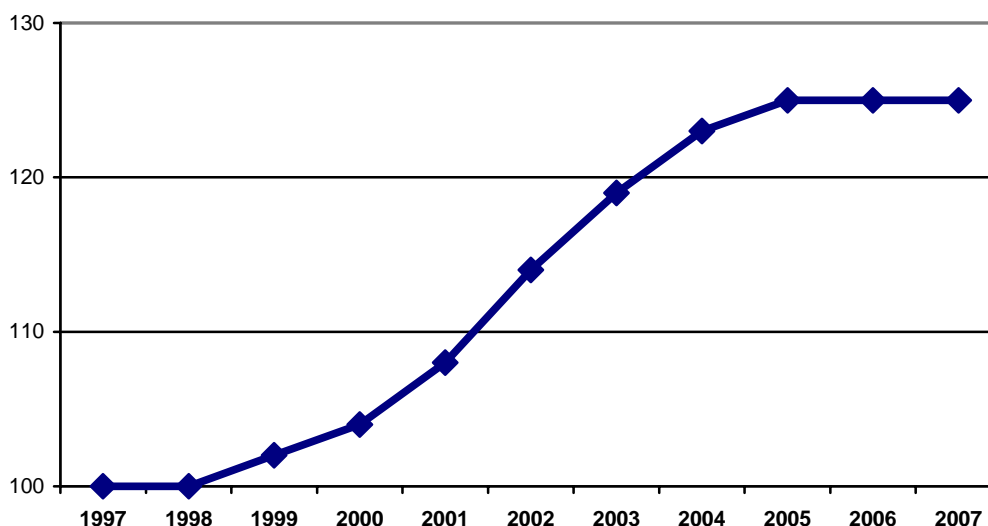
Sources: England: non medical staff census, The Information Centre, NHS. Northern Ireland – DHSSPSNI; data is for March; Scotland data - ISD Workforce Statistics; Wales – SDR 43/2008. Note: % figures are rounded.

NOTE: Data for England includes bank nurses; data for other three countries does not. Scotland data is for 2006; in 2007 data collection was re-calibrated using Agenda for Change bands at it is not possible to conduct a like for like comparison.

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. The growth in numbers has now tailed off; and generally speaking the last two to three years have seen a flat-line in overall NHS qualified nurse staffing numbers, after rapid growth in the late 1990s and earlier part of this decade. Figure 1 shows the staffing growth in England for registered nurses over the period since 1997. The lack of

growth over the period since 2005 contrasts markedly with the rapid pace of growth in 2000-2004.

**Figure 1: England: NHS Qualified Nursing Workforce-  
% growth, 1997=100**



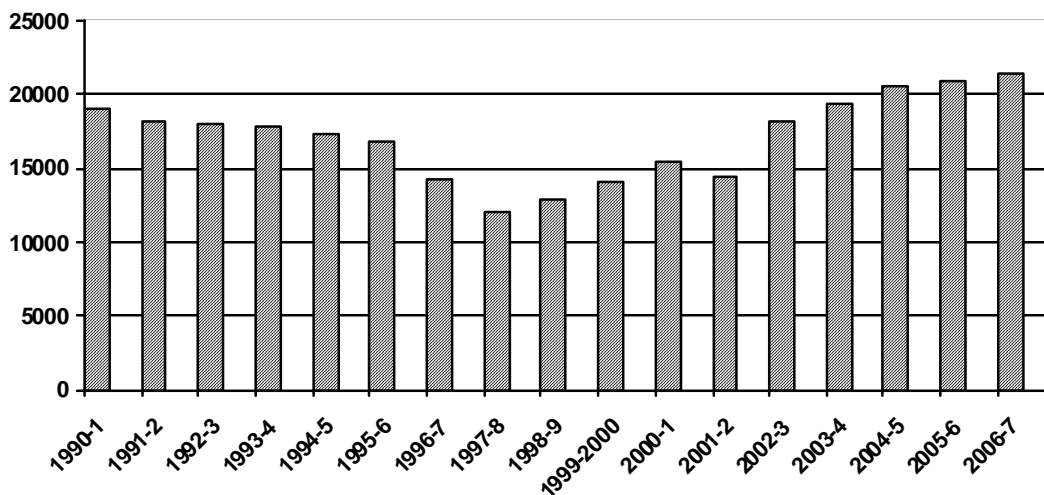
Source: Information Centre

### **Drivers for recent growth... and current stagnation...**

The governments in the UK, notably England, invested in growth 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 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. 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.

There was then a significant upward trend between 1997/98 and 2006/07 (the latest year for which NMC data is available); the new intake from UK education exceeded 20,000 in 2004/05, and exceeded 21,000 in 2006/07. There is a lag of several years between decisions on funding levels for pre-registration nurse education and these new nurses entering the register. There were reductions in commissioning in 2005/06 which are likely to play through to training output declines in 2009. A later section of this report gives 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 2006/7**



Source: NMC/UKCC.

The recent growth in numbers entering the register has not driven further growth in NHS employment of nurses. NHS funding constraints have significantly reduced demand for new nurses compared with four or five years ago.

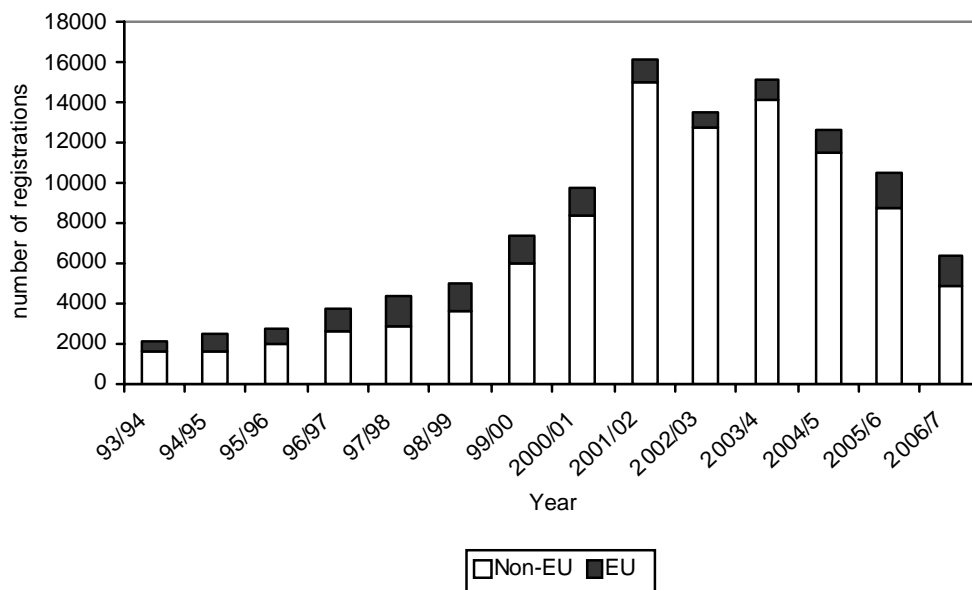
### **The not so quick fix and rapid decline of international recruitment**

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. 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.

More recently a bundle of self imposed policy changes have made it much more difficult for non EU nurses to enter the UK. In 2005 the Nursing and Midwifery Council instigated a much tougher (and costlier) programme for overseas nurses to comply with registration requirements. In 2006 the main entry clinical grades in the NHS were removed from the Home Office shortage occupation list, making it much more challenging for UK employers to recruit internationally. 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.

The massive pendulum swing of overall levels of recruitment of international nurses, from low reliance, to high reliance, back to low reliance in the space of less than 10 years is shown in data from the NMC (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). The key indicator is the level of new registrants on the NMC Register who have come from outside the UK.

**Figure 3 : Admissions to the UK nursing register from EU countries and other (non EU ) countries 1993/94 - 2006/7**



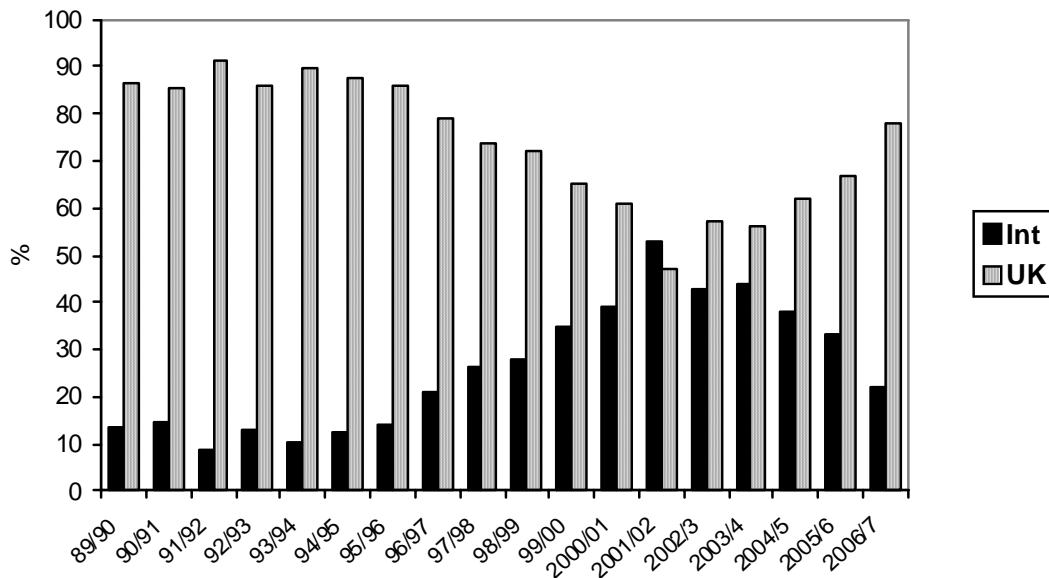
Source: NMC/UKCC

Rapid growth in the annual numbers of entrants to the UK register from overseas in the late 1990s and earlier years of this decade is highlighted in Figure 3. Nurses from EU countries have not shown the same pattern of decline (but neither have they grown in significant numbers – although there has been a marked increase from Poland in recent years.) The NMC data is now more than a year out of date; more recent data would show a further drop in the number for overseas entrants.

The pendulum swing of reliance on international nurses is highlighted in Figure 4, which shows the relative contribution of UK and 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.

**Figure 4: International and UK sources as a % of total new admissions to the UK nursing register, 1989/90 - 2006/7 (Initial Registrations)**



Source: UKCC/NMC data

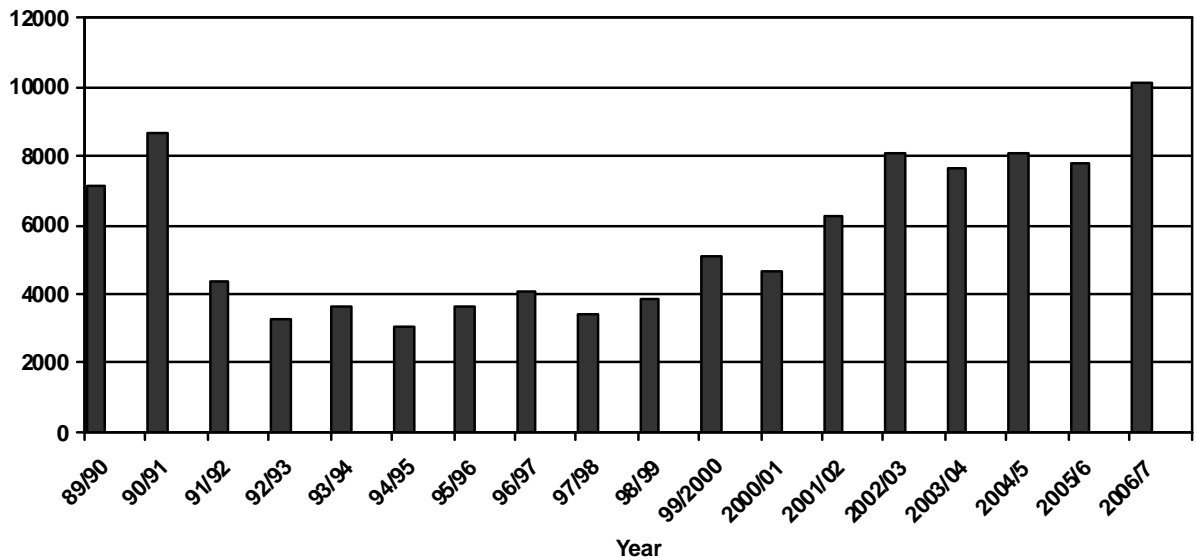
As noted earlier, one of the reasons that active international recruitment has been so attractive to policy makers in the UK is that it offers a quick fix. The nurses have been trained elsewhere, at someone else's expense, and can be recruited and working in the UK within a few months, not the four years 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 what has happened in the UK; which has been compounded by changes in entry requirements for nurses to the UK. Currently, recruiters cannot employ non EU nurses on Agenda for Change band 5 and 6 (other than in some designated specialities); this has been cited by the Registered Nursing Homes Association as being a contributor to nurse shortages in the care home sector<sup>14</sup>.

#### **From net importer to net exporter of nurses?**

Recent UK nursing press stories have suggested that overseas recruiters are deliberately targeting the UK. Some estimates 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 (The NMC data indicates an intention to nurse in other countries; it does not necessarily record an actual geographical move).

**Figure 5: Annual no. of verifications issued by NMC/ UKCC, 1989/90 - 2006/7**



Source: NMC/UKCC

Overall trends in outflow are shown in Figure 5. The number of verifications issued declined in the first half of the last decade. There was then a rising trend, followed by a period of stability in 2002-2006. There has since been a notable “spike” in 2006/07. Nearly half of all verification requests in 2006/07 were for Australia, and it was the growth in the numbers of UK registered nurses applying for verification in Australia that largely accounted for the overall growth in verifications (some may be Australian nationals currently registered in the UK who are returning home).

### **The next few years...**

Modernising Nursing Careers, the policy shift towards more care being delivered in the community, and the NMC endorsed shift to all graduate entry all have implications for nursing in each of the four UK countries.

The Workforce Review Team has recently published its annual assessment of NHS workforce priorities in England<sup>15</sup>. For nursing, it notes that a number of forthcoming developments will impact on the future nursing workforce. These include the potential for Modernising Nursing Careers to direct career pathways; the implications of moving to all graduate entry; and WRT highlights that the “full implications of the NSR for nursing still need to be worked through at local and national levels”.

WRT comments that “overall supply of the nursing workforce largely meets demand”. However they forecast that “if current commissions are maintained there will be a slight reduction in the number of nurses available in the future”<sup>16</sup>. WRT projections suggest 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 improve<sup>17</sup>.

The WRT suggest that mitigation strategies for NHS nursing should include a focus on retention and development of the current NHS workforce; that PCTs and employers should look to increase availability of community placements; and that there was a need for recruitment initiatives to encourage nurses to work in a primary care setting.

It is clear from the available evidence that there is unlikely to be any significant growth in NHS nursing numbers – in England at least – over the next few years, and probably a slight decline, unless policy priorities change. Similar modelling data is not available in the public domain for the other UK countries, but the information analysed later in this report suggests that recent intakes to pre-registration nurse education courses in all four UK countries have been declining.

### **3. The UK'S future: supply from training and education**

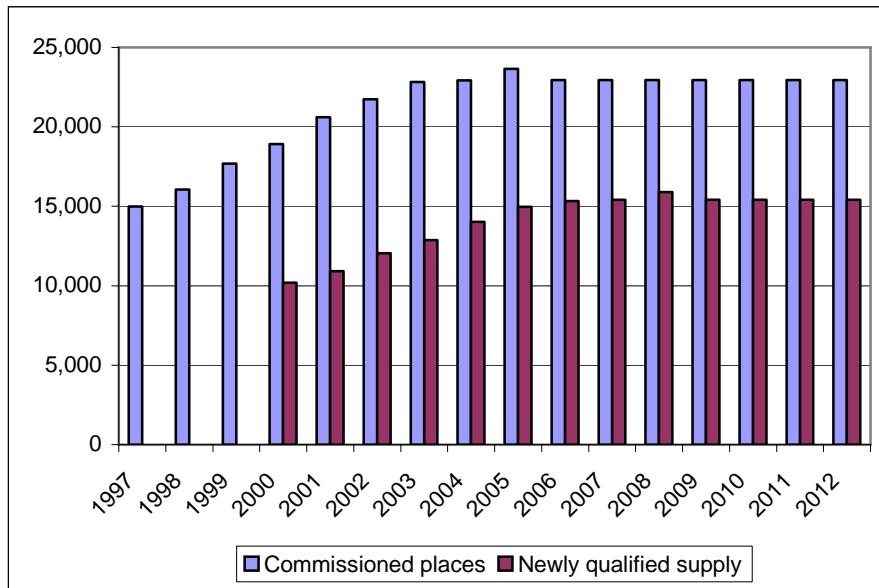
As noted in the previous chapter, the NHS Workforce Review Team (WRT) has recently published its *Assessment of Workforce Priorities* (2008). It sets out key national (England) priorities and issues for the health care workforce in the context of the priorities identified in the *Next Stage Review* and the continuing expectation that some activity – and staffing – will move from large hospitals into community settings.

The WRT assert that supply largely meets demand in terms of the overall nursing workforce and conclude that, in order to ensure this balance is sustained, SHAs need to review their commissioning levels in the light of forecasts. In midwifery, by contrast, they conclude that SHAs will need to work with PCTs and providers to enable the planned recruitment (announced in February 2008) of an additional 4,000 midwives over the next three years through increased training as well as improvements in recruitment, retention and return to practice.

Pre-registration commissioning levels were last forecast in October 2007 by WRT based on assumptions about, for example, growth in the nursing workforce, attrition from training and participation rates of newly qualified nurses. They forecasted 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 are set at 22,941 per year. In practice SHAs actually commissioned marginally fewer places (1.3% or 22,635) than this in 2006/07 (we assume that 'maintain' commissions at current levels means at this lower level).

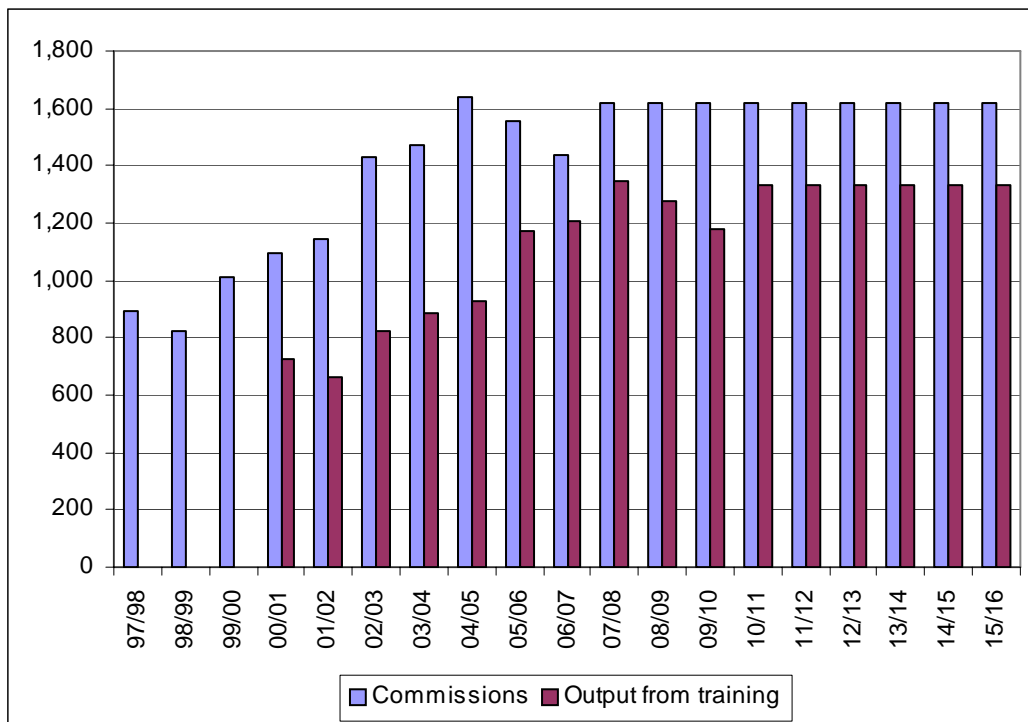
In midwifery, commissions were forecast as growing to 1,622 a year from 2008 with an expected output of 1,481 per year. Figures 6 and 7 show forecasted commissions and outputs from training for nursing and midwifery respectively. A new forecast reflecting the expected increase in staffing levels has not yet been made available. Figures published by WRT show that at 1,990, actual commissions in 2006/07 were higher than the model forecast and that planned commissions for 2007/08 were reported as 2,116.

**Figure 6: England: planned commissions and expected output for pre-registration nursing 1997 to 2012**



Source: based on WRT nursing proforma 2007

**Figure 7: England: planned commissions and expected output for pre-registration midwifery 1997/98 to 2015/16**

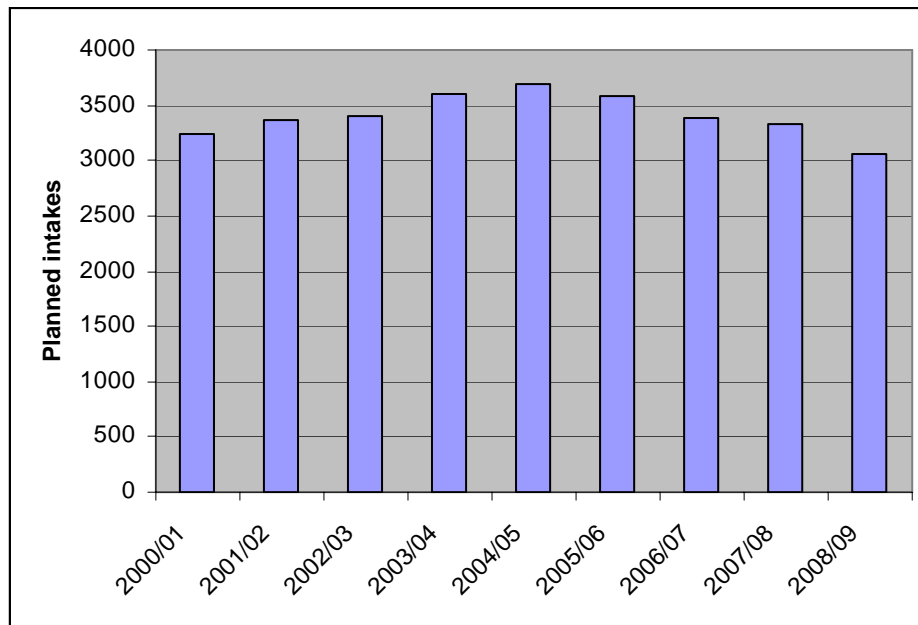


Source: based on WRT midwifery proforma 2007

In Scotland a similar annual exercise – the Nursing and Midwifery Workforce Planning Process (formerly known as SNIP – Student Nurse Intake Planning –SNIP) – recently

recommended intakes for 2008/09 of 3,060. This represents an 8 % reduction in intakes compared with the previous year. While the overall intake is expected to reduce, the number of midwifery places will rise from 172 in 2006/07 to 220 in 2008/09. Nursing intakes are expected to reduce to 2,840. Figure 8 shows the intake recommendations from SNIP/NMWP from 2000/01 to 2008/09.

**Figure 8: Intake recommendations for pre-registration nursing and midwifery in Scotland, 2000/01 to 2008/09**



Source: NHS Scotland

The remainder of this section assesses recent trends in applications for, and uptake of, education places in nursing and midwifery. What do these trends tell us about the future supply of newly qualified staff? We will focus primarily on England and Scotland. In Wales the new integrated workforce planning process for NHS Wales has only recently (June 2008) been launched and health economies are not required to submit commissioning requirements until early September. Consequently, comparable projections are not currently available for Wales. In Northern Ireland the recently published *Nursing and midwifery update review* (2008) provides limited information; the previous report (2005) forecast intakes from training of 651 per annum each year from 2005 to 2009. For the sake of completeness we will provide figures on trends in student numbers in all four countries wherever possible. Although the available data do not enable us to comment specifically on education and training for roles that are specific to acute or community settings, understanding trends in the overall numbers

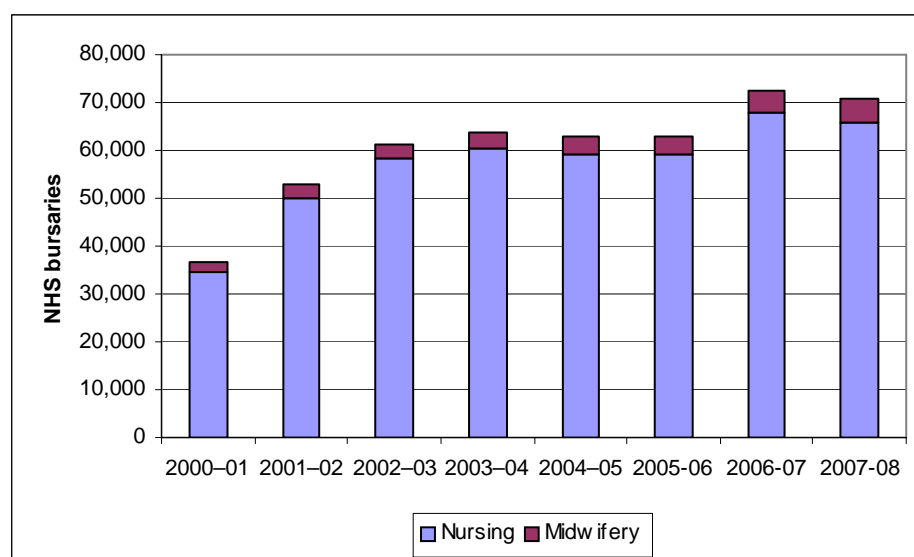
are clearly important and will play a significant role in helping to determine the rate at which changes in the nursing workforce happen.

### The student population

How many pre-registration nursing and midwifery students are there in the UK? An apparently straightforward question, but difficult to answer. 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 2007, there were 88,875 students on full-time (more than 24 weeks) 'undergraduate' nursing courses in higher education institutions across the UK, some 3.7 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 (but still 'undergraduate') courses.

The numbers of pre-registration nursing students in receipt of non-means tested NHS bursaries (Figure 9) in England provides a 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 almost 68,000 in 2006/07, falling back to 66,000 in 2007-08. A further 4,645 midwifery students received NHS bursaries in the academic year 2007-08 (compared with 4,532 in the previous year). In total these figures imply that there were no fewer than 70,650 pre-registration nursing and midwifery students in England in 2007-08, some 2.5% fewer than in 2006-07.

**Figure 9: England: numbers of pre-registration nursing and midwifery students with NHS bursaries 2000-01 to 2007-08**



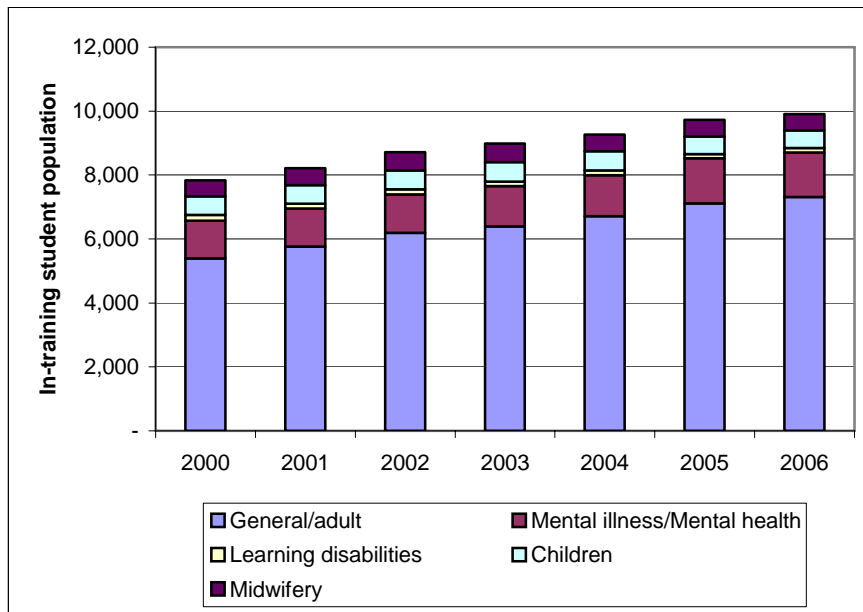
Source: House of Commons, Hansard, *Written answers*, 13 December 2004, 18 May 2006, 6 June 2006 and information obtained in FOI request 421408

The latest publicly available figures indicate that there were approximately 15,770 pre-registration nursing and midwifery students enrolled on courses in Scotland, Wales and Northern Ireland in Spring 2006:

- **Scotland:** latest available figures show an all-time high in 2006/7 of 9,909 first level nursing and midwifery students in Scottish higher education institutions (and paid for centrally). This represents an increase of 1.8% (183) since 2005/6. Adult branch students account for nearly three-quarters (74%) of this total.
- **Wales:** more recent figures are available and these show that the in-training population has declined slightly (1.6%) from a peak of 3,672 in 2005/06 to 3,615 in 2007/08. Adult branch students account for three-quarters of this total.<sup>18</sup>
- **Northern Ireland:** 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.<sup>19</sup> This is 150 (6.4%) fewer than in 2005/06.

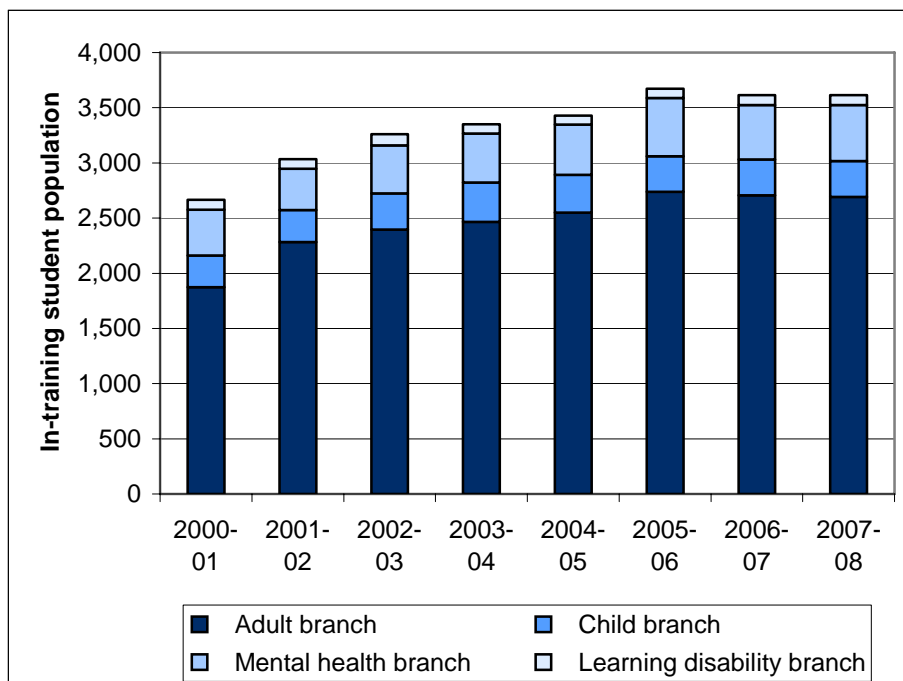
Figures 10 and 11 below show the distribution of the in-training student population by branch and recent trends for Scotland and Wales respectively. Comparable data for Northern Ireland are not available; figures on training places commissioned, which may be a reasonable proxy, are reported later (courses in Scotland which commence in autumn 2010 will also be processed via the UCAS system).

**Figure 10: Scotland: population of pre-registration nursing and midwifery students, 2000/01 to 2006/07 by branch**



Source: ISD, NHS Scotland Workforce Statistics

**Figure 11: Wales: population of pre-registration nursing students by branch, 2000/01 to 2007/08**



Source: Health Statistics Wales

### **Flows into nursing education**

Figures on the numbers of students entering nursing education are also becoming scarcer. Only limited data are available on numbers of entrants to pre-registration education in Northern Ireland, Scotland and Wales.

In England, the Nursing and Midwifery Advisory Service (NMAS), which has 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. This section uses data from the eighth and final statistical report from NMAS covering applications to pre-registration nursing and midwifery training diploma programmes for the year 2007. Applicant and intake data are unlikely to be available in this level of detail in the future.

### **Intakes to nursing and midwifery education in England**

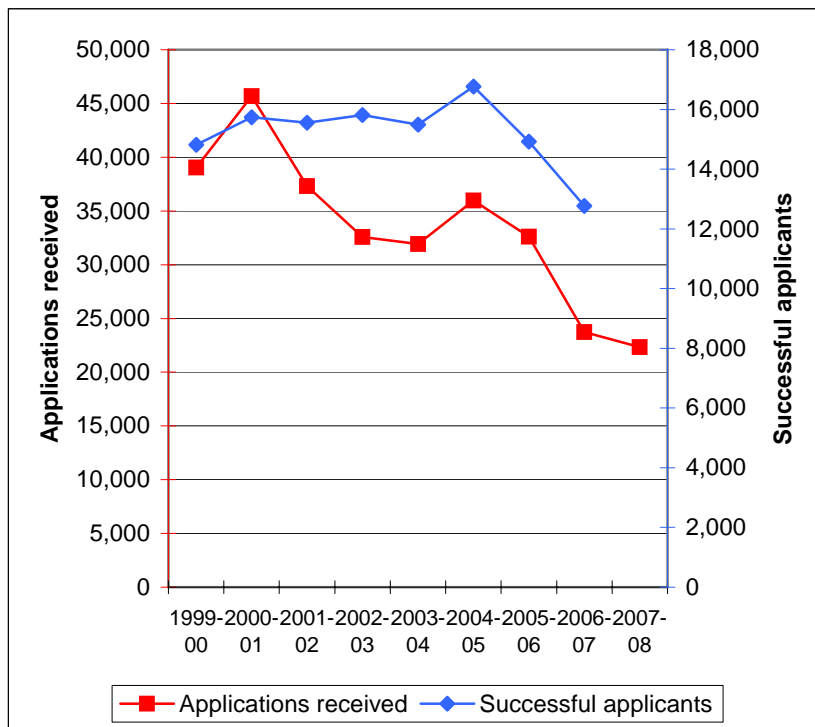
In 2004-05 NMAS received applications from just under 36,000 individuals for entry to diploma courses. Since then the numbers have dropped sharply, by almost 6% in 2005-06 (32,623) and by 27% in 2006-07 (23,722).

The 23,722 applicants in 2006-07 represent the lowest number ever recorded by NMAS. Figures released by UCAS in July 2008 suggest that the decline has continued: 13,406 people applied solely to courses that were previously available through NMAS and a further 8,932 applicants included one or more choices to courses that were previously available through NMAS. This suggests a total of 22,338 applicants – a further 5.8% drop on the number of applicants in 2006-07 and more than a third fewer than just three years ago. Figure 12 shows trends in applications and acceptances.

Inevitably the numbers of successful applicants have also fallen sharply, dropping 11% in 2005-06 and a further 14.5% in 2006-07. In 2006-07 there were only 12,673 successful applicants, the first time that the number has dipped below 14,000. Figures for 2007-08 are not yet available but assuming a ‘success rate’ of 54% as in 2006-07 then we would expect an intake of roughly 12,000 students to diploma courses this year.

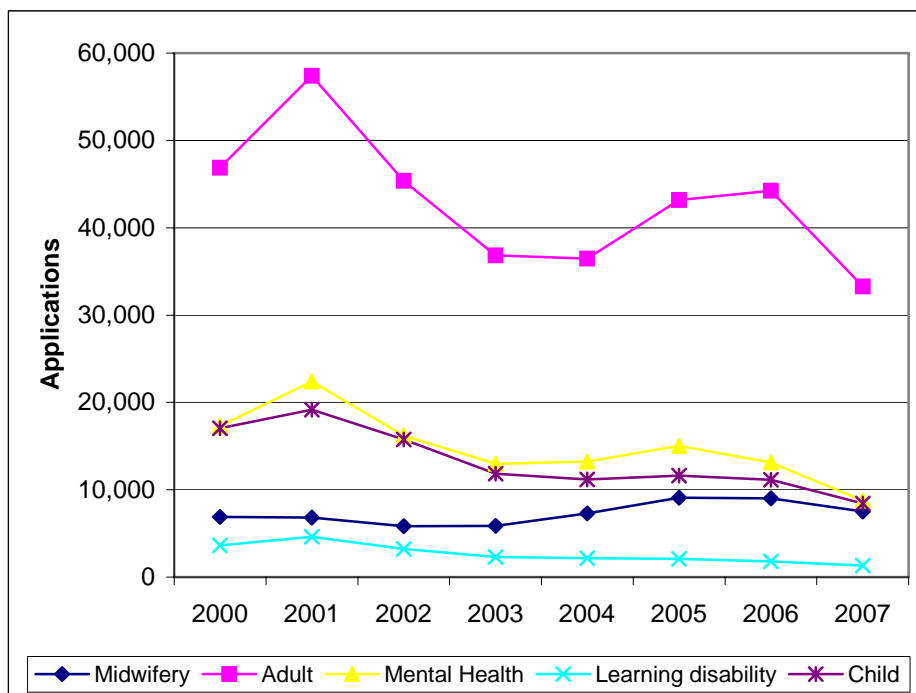
Figure 13 shows the trends in applications by branch. While the reductions have affected all branches, the decline is steeper in some than others, ranging from a low of 16.4% in midwifery to a high of 33.2% in adult branch.

**Figure 12: England: trends in applications for diploma level pre-registration nursing and midwifery programmes, 1999-00 to 2007-08**



Source: NMAS/UCAS

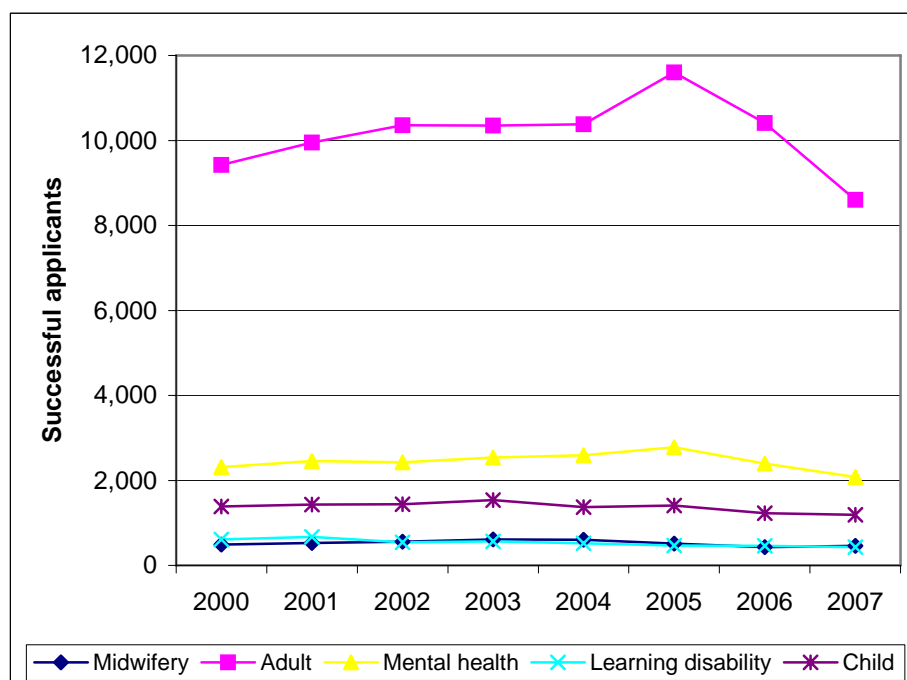
**Figure 13: England: applications for full-length diploma level pre-registration nursing and midwifery programmes 2000 to 2007, by branch**



Source: NMAS

In contrast, the impact on acceptances has been mixed, with midwifery actually increasing slightly (albeit from a comparatively lower base) and child branch falling much less (2.9%) than the adult branch (down by over 17%), or mental health (down 13.3%).

**Figure 14: England: acceptances for full-length diploma level pre-registration nursing and midwifery programmes 2000 to 2007, by branch**

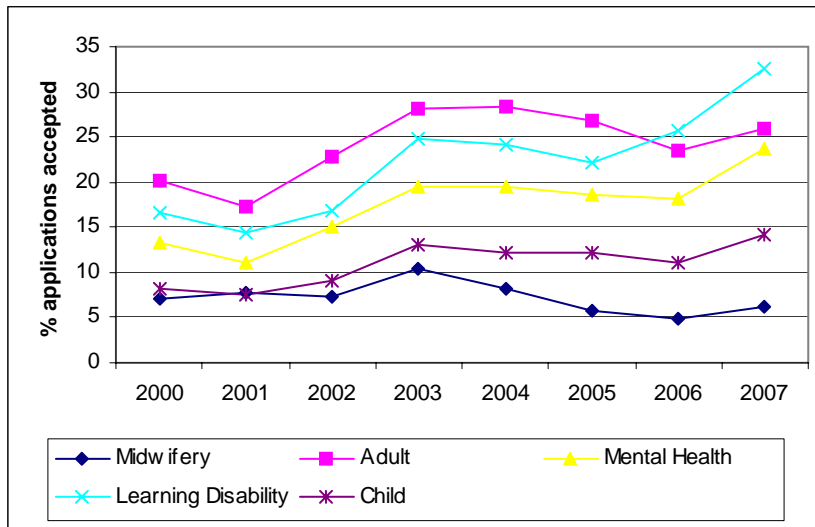


Source: NMAS

Since 2000 the overall proportion of applications accepted has increased from about one in seven (15%) to just over one in five (21%). These acceptance or ‘success’ rates differ widely between the five branches (Figure 15). For example, 6% of applications to midwifery were accepted compared with almost 26% of applications to the adult branch. All five branches show a marked increase in acceptance rates in 2007.

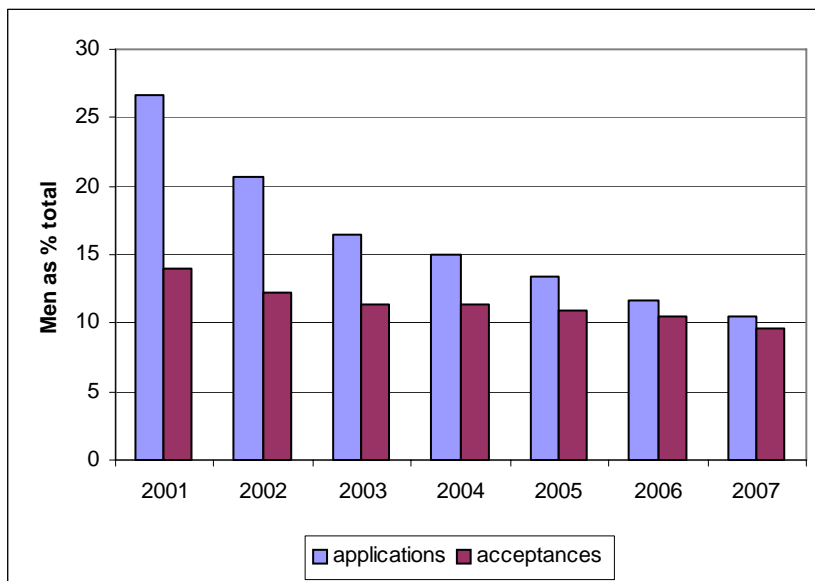
Two other key trends are apparent in the figures. Firstly, there has been a continuing fall in the share of applications from men (Figure 16) – down from a peak of 26.6% in 2001 to just 9.3% in 2007 – and in their share of acceptances (down from 14% in 2001 to 9.6%). Male student nurses are increasingly concentrated in the mental health and learning disability branches which now account for 48% of accepted male applicants (compared with 42% in 2002 and with under 17% of accepted women applicants).

**Figure 15: England: percentage of applications accepted by branch, 2000 - 2007**



Source: NMAS

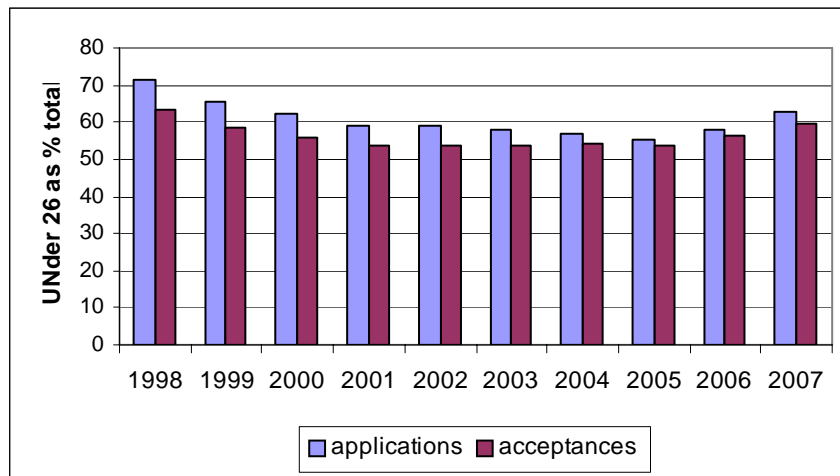
**Figure 16: England: men as a proportion of all applications and acceptances for full-length diploma level pre-registration nursing and midwifery programmes, 2001 - 2007**



Source: NMAS

Secondly, there has been a marked shift in the age profile of those applying. From 1998 to 2005 the proportion of applicants aged under 26 gradually declined from 71.5% to 55.4%. Since 2005 that trend has reversed, with almost 63% of applications in 2007 coming from the younger age group.

**Figure 17: England: share of applications and acceptances for full-length diploma level pre-registration nursing and midwifery programmes of those aged under 26, 1998-2007**



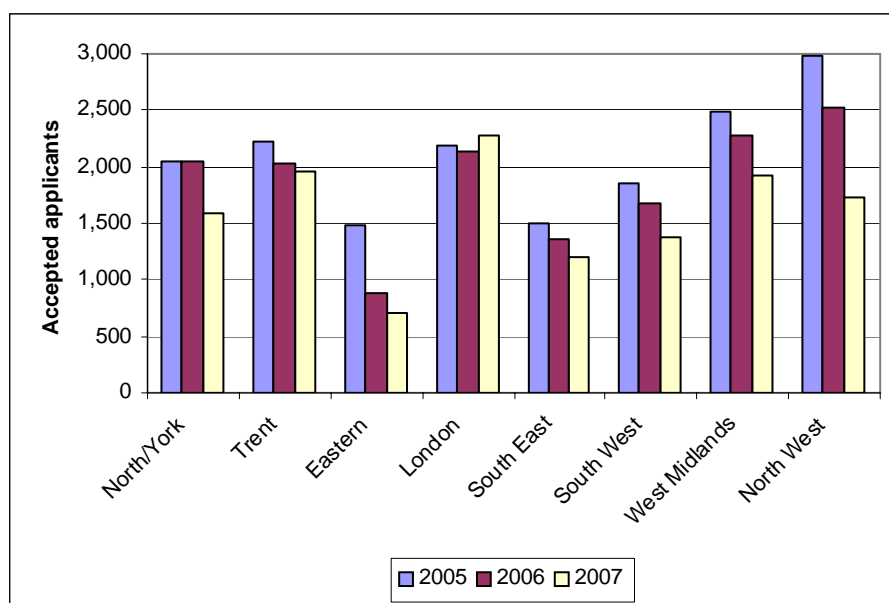
Source: NMAS

Prior to 2007 the trend was for the percentage share of applications from those aged 25 and under to fall. From a peak of over 70% in 2000 their share had dropped to 55% in 2005. That trend has reversed in 2006 and 2007 when it rose to 58% and 63% respectively. Similarly, younger applicants' share of acceptances is also increasing (Figure 17). In 2007 there were 37,163 applications from students aged 25 and under, of which nearly 60% (7,633) were accepted. Nevertheless, older applicants are still marginally more likely to be accepted (23% compared with 20.5% of those aged 25 and under).

The overall fall in the number of accepted applicants has not been felt evenly. In contrast to the rest of the country, universities and colleges of higher education in London experienced an increase (of 7% or 150 more students) compared with a fall (of almost 32% 796 fewer students) in the North West (Figure 18) and of 22% (453 students) in Northern/Yorkshire region. As a result, London now accounts for the largest proportion (almost one in six) of all accepted applicants for the first time.

One unexplained trend is that of a sharp increase in the number of applicants from outside England. In 2005 only 334 accepted applicants (2%) were from outside England including 157 from elsewhere in the UK (the largest number of these was from Wales). In 2006 the total increased to 686 (4.6%) and in 2007 to 749 (5.9%). The numbers of accepted applicants from Scotland, Wales and Northern Ireland have continued to fall (dropping to 113 in 2007) but those from outside the European economic area have risen from fewer than 40 in 2005 and 2006 to 574 in 2007.

**Figure 18: England: applications and acceptances for full-length diploma level pre-registration nursing and midwifery programmes 2005, 2006 and 2007, by region of institution**



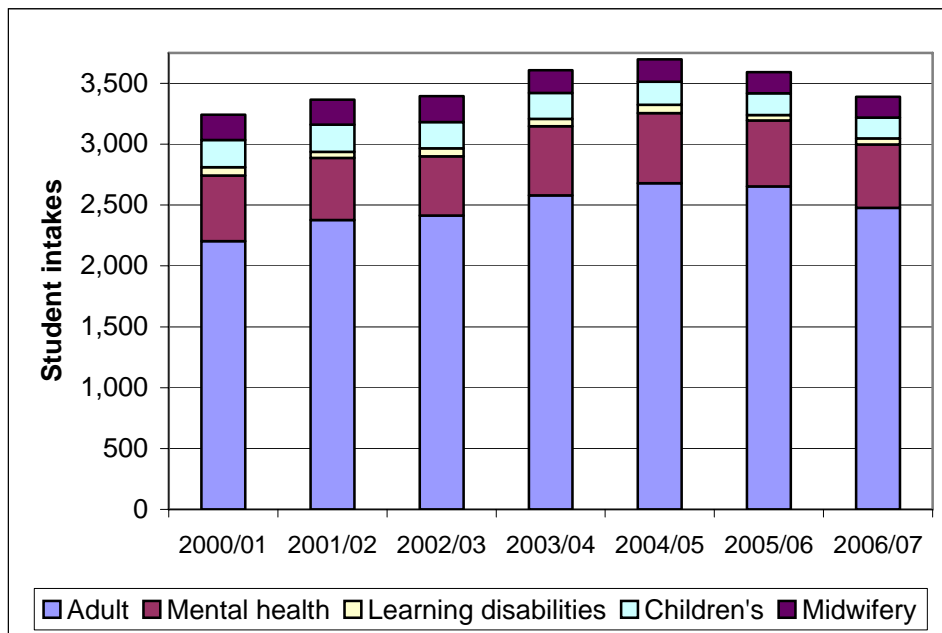
Source: NMAS

In terms of applications to degree level nursing and midwifery education, the number of applicants in England has risen steadily from just under 9,000 in 2004 to just over 12,000 in 2007. However, the number of acceptances peaked at 4,815 in 2006, falling back to 4,748 in 2007.

### **Intakes to nursing and midwifery education in Scotland, Wales and Northern Ireland**

Trends in the other three countries of the UK largely follow the same pattern as in England. Intakes to pre-registration courses in Scotland have also fallen since peaking at 3,698 in 2004/05. In 2005/06 they fell by 2.9% and in 2006/07 by a further 5.6% to total 3,391 – the lowest figure in the last five years.

**Figure 19: Scotland: numbers of students starting 3-year nursing and midwifery programmes, 2000/01 to 2006/07**



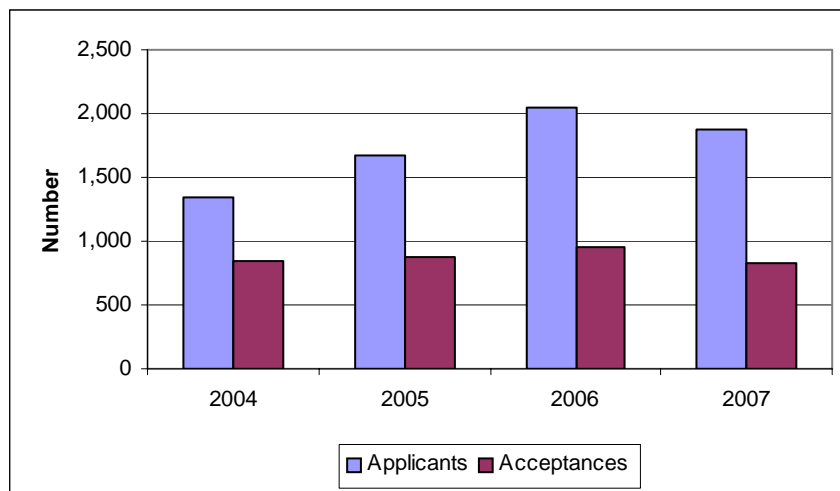
Source: ISD

A fall of 6.7% (178) in intakes to the adult branch accounts for most of this decline; other sectors reduced by single figure numbers and the intake to learning disabilities increased marginally.

The numbers of applicants for degree level nursing and midwifery education in Scotland declined to 431 in 2007, compared with a peak of 461 in 2006; acceptances dropped to 216 compared with 282 in 2005.

In Wales there has been a move to all pre-registration nursing education at university degree level. 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. Acceptances have followed a similar trend, peaking at 948 in 2006 and falling to 828 in 2007.

**Figure 20: Wales: applicants and acceptances for degree level pre-registration education, 2004 to 2007**

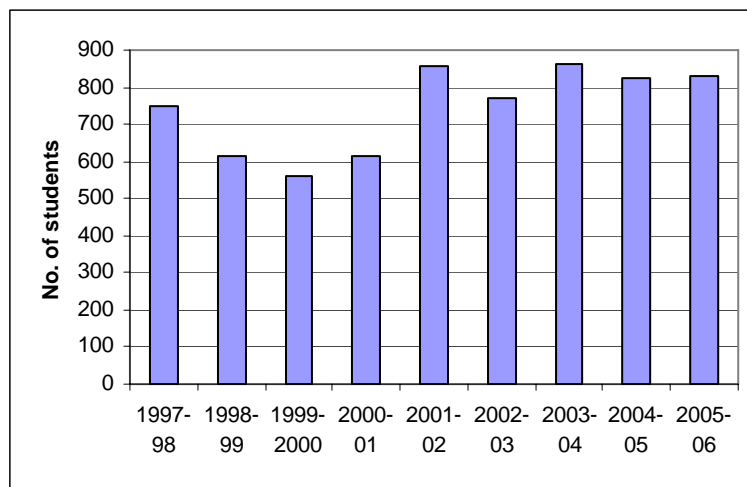


Source: UCAS

Figure 21 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 three most recent years for which data are available. Figures on the numbers of places commissioned are shown on Table 2. The DHSSPS commissions around 730 pre-registration nursing places per year, slightly smaller than the 750 a year prior to budget cuts in 2005.

The number of places commissioned for mental health nursing is expected to rise to 117 in 2008/09. For midwifery, the in-training population is 102 (of which 63 are on direct entry and 39 on an 18-month programme). Figures from UCAS show that the number of applicants to degree level courses in Northern Ireland has fallen from a peak of 758 in 2005 to 712 in 2007, with 405 acceptances.

**Figure 21: 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

**Table 2 Northern Ireland: pre-registration nursing and midwifery, commissioned training places, 2001, 2004 and 2008**

	2001	2004	2008
<b>Adult</b>	560*	620	570
<b>Child</b>		40	40
<b>Mental Health</b>	60	90	90
<b>Learning Disability</b>	30	30	30
<b>Midwifery**</b>	40	48	44
<b>Total</b>	690	828	774

Source: DHSSPS, 2005 and 2008

Notes: 2001 combined figure for adult and children branches; \*\*Midwifery figure includes 18-month programme places (in 2008 there were 20 of these)

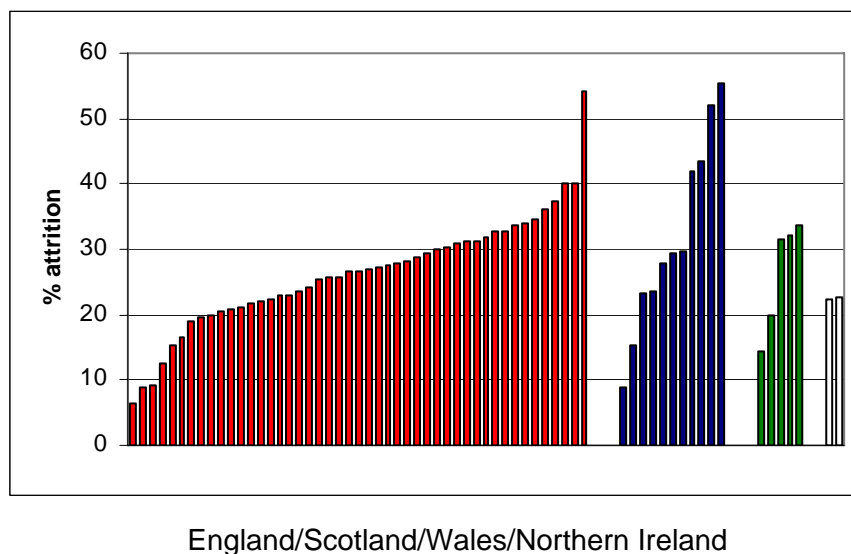
### Non-completions

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. 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* requested 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% (ranging from 22.4% in Northern Ireland to 26.7% in England). They also show:

- a wide range, from 6% to 56%, between institutions (see Figure 23)
- drop out rates were highest in Greater London and south east England (32%)
- drop out rates were higher for those on diploma courses (28.1%) compared with those on three year degree courses (20.3%).

The same exercise conducted two years ago reported an overall attrition rate of 24.2% ranging from 7% to 47.5%.

**Figure 22. Attrition among students who began pre-registration diploma and degree courses in 2003**



Source: data from *Nursing Standard*

The latest estimates used by the WRT in forecasting the supply of newly qualified registered nurses for England, assumes an attrition rate of 20% a year from 2006 onwards. This is slightly higher than the estimate used for the period prior to 2006 and much higher than the 13% target set by the Human Resources Performance Framework in October 2000. The 20% figure is based on a ‘consensus’ view from various stakeholders.

In Scotland, the 2006 national workforce plan reports that attrition rates remain ‘relatively high’ at just over 26% (the figures obtained by the *Nursing Standard* indicate a figure of 25.7% in Scotland). These figures (which include transfers between branches) are similar to those of previous years and are not indicative of any improvement; it is not clear that the method of measuring attrition is the same in the four UK countries<sup>20</sup>, and therefore cross country comparison may not be comparing like with like.

## **Form should follow function: addressing the real priorities that face the nursing workforce**

The current policy focus has been on developing new structures for NHS workforce planning in England. New structures will not in themselves enable the key priority challenges to be solved; and implementing these could be a distraction from addressing the issues. The Health Committee in its 2007 report notes that the NHS in England did not need more restructuring, it needed aligned workforce planning, supported by sufficient technical and strategic workforce planning capacity.

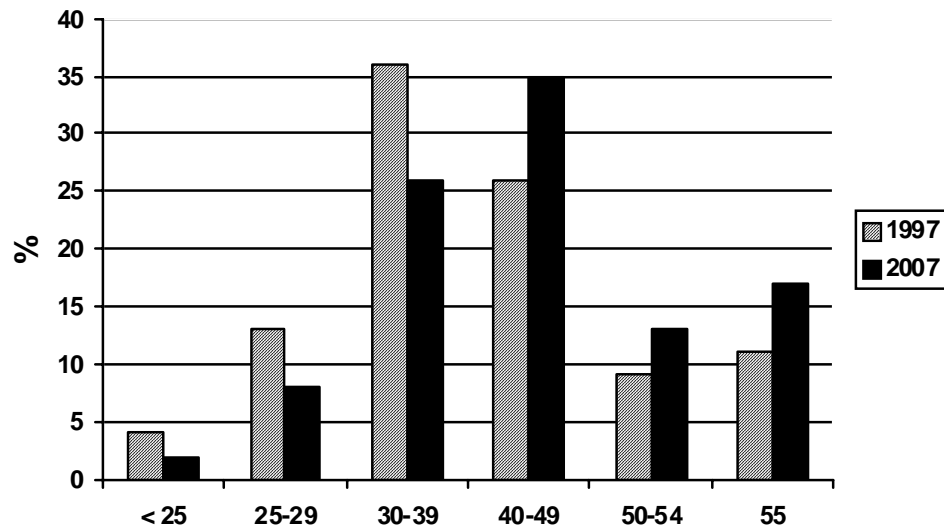
There are two looming workforce challenges that can be identified with total certainty, which the NHS is as yet poorly prepared for. The first is entirely predictable and cannot be avoided – the impact of the ageing of the NHS nursing workforce. The second is self imposed, but as yet has received scant consideration – the workforce challenges of supporting the Darzi-led shift from acute to community/ primary care.

### **Dealing with the ageing of the workforce**

The UK nursing population, as with many others in the developed world, is ageing. In 1991 one in four (26%) of all those on the NMC Register were aged under 30; by 2006/7 fewer than one in ten were under 30. At the same time, the proportion of registrants aged over 55 has grown to 17 %.

Figure 23 shows the shift of the age profile of nurses on the UK register over the 10 year period 1997-2007. About 200,000 nurses on the register were aged 50 or older in 2007. To an extent the large scale international recruitment earlier in this decade helped the NHS stave off the impact of ageing on the UK nursing population as many of the recruited international nurses were younger than the UK average. But the overall impact of ageing cannot be avoided, and will become more pronounced.

**Figure 23 : Age profile, UK Nursing Register 1997 and 2007**



Source: NMC

Firstly, the numbers of registrants leaving the register is bound to increase as the large cohorts aged 50 plus move into retirement 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<sup>21</sup>. Secondly, those older nurses who continue to participate in employment are less likely to work full-time, if past trends are continued. The RCN membership surveys have shown consistently that the proportion of nurses working full-time falls in older age groups.

The NHS in England and Wales agreed changes to the pension scheme for nurses in April 2008. There will be two separate schemes:

- **The NHS pension scheme**

This is the current 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 new NHS pension scheme**

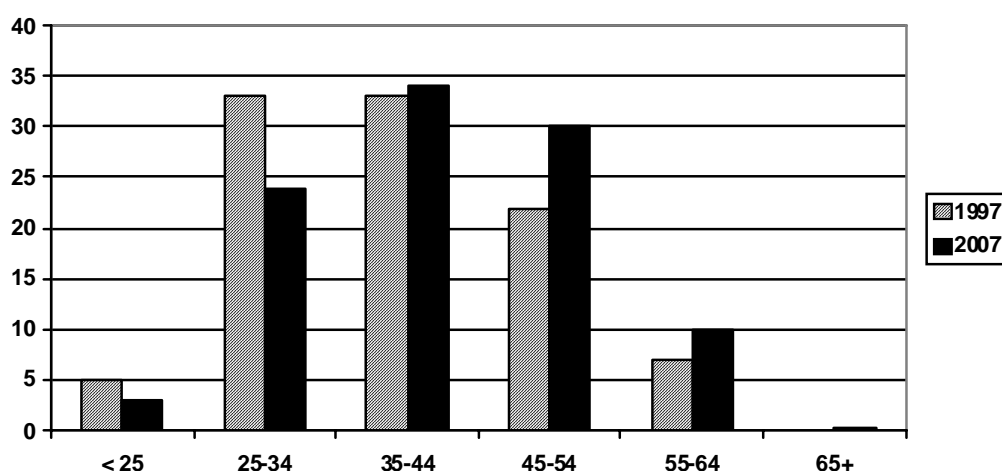
This is a new final salary scheme for anyone who joins on or after 1 April 2008. It will have a normal pension age of 65, a higher accrual rate and a different set of rules and benefits.

In Scotland the NHS pension scheme has also changed. For most members the minimum age at which pension will normally be paid is 60. For those who join from 1 April 2008 normal pension age will be 65.

This change is far less radical than the government wished to achieve, and 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.

The retirement age of NHS nurses is particularly important in assessing the availability of current NHS staff over the next 5-10 years. Paralleling the age profile on the NMC Register, there has been a marked ageing in the NHS nursing workforce (Figure 24), partly a result of the reductions in student nurse intakes in the early/ mid 1990s, and partly as a result of the emphasis on attracting returners. The increase in average age of student nurses will also have contributed to this ageing profile.

**Figure 24: Age profile of NHS qualified nurses, England, 1997 and 2007**



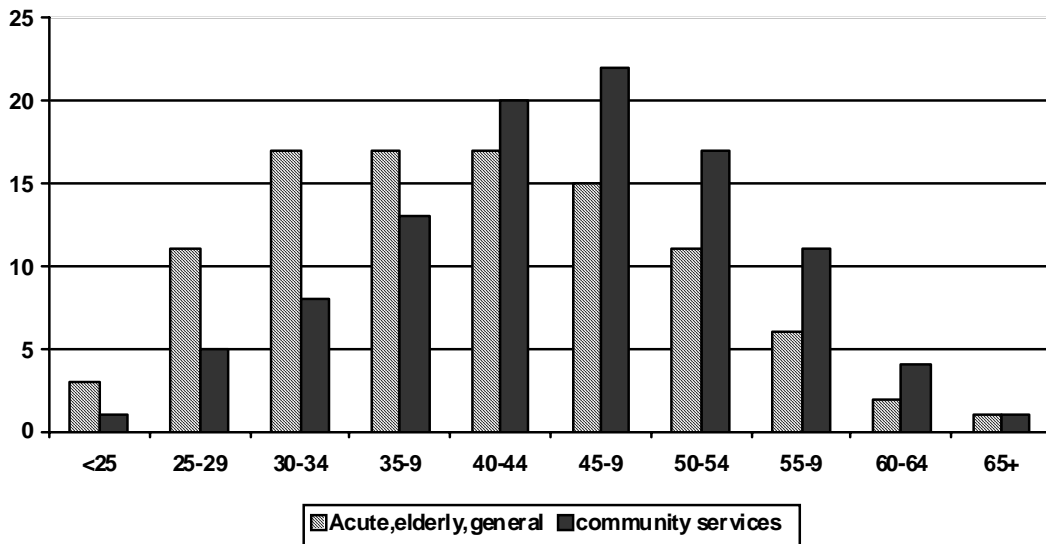
Source: Department of Health/ The Information Centre, NHS

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.

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 25). This means that the impact of growing retirements will hit the community sector earlier and harder. The NHS Workforce Review Team report 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”<sup>22</sup>.

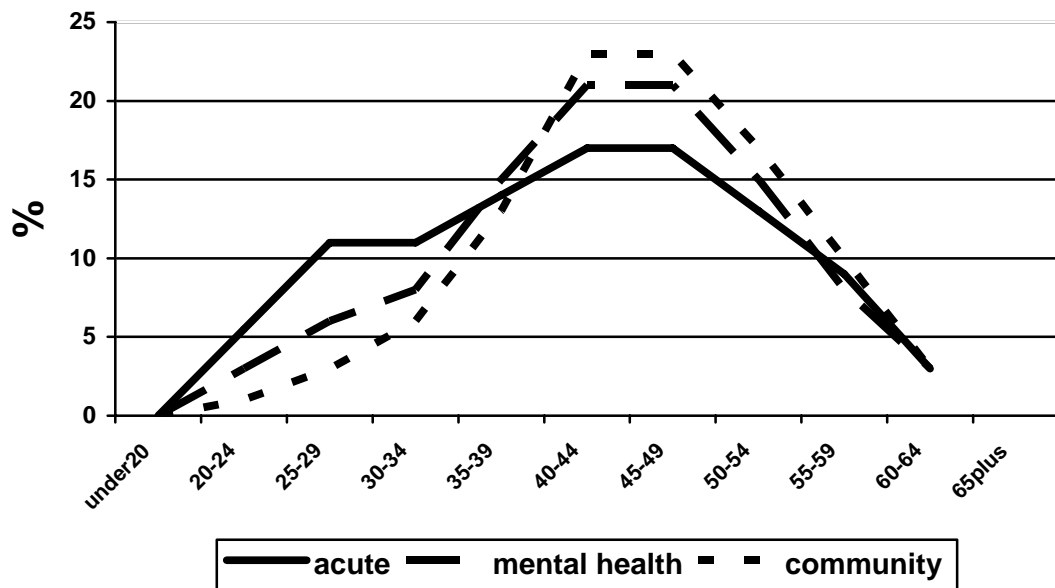
**Figure 25 : Age profile, NHS nurses- acute/care of elderly/general, and community services,England, Sept 2007**



Source: Department of Health/ The Information Centre, NHS

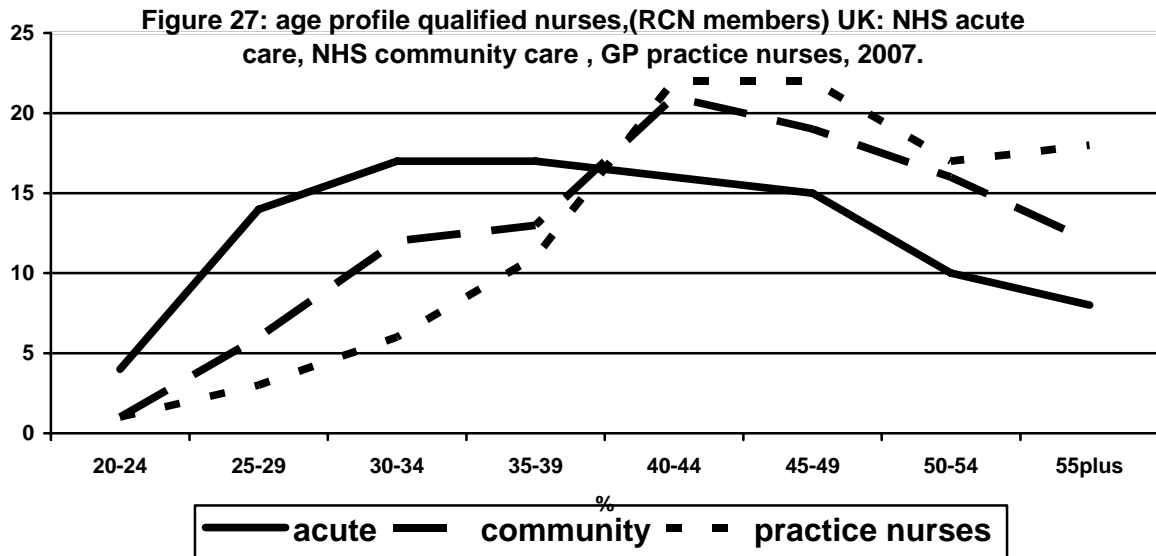
A similar pattern is seen in the other UK countries. Figure 26 below shows the September 2007 age profile for three main groups of qualified nurses in NHS Scotland – nurses working in hospital acute care, nurses working in hospital mental health, and nurses working in community care.

**Figure 26: Age profile, NHS qualified nurses, Scotland, by location of service delivered, September 2007**



Source: ISD

Age profiles for all three groups peak in the 40-50 age bands, but the acute/ hospital group has a notably younger overall profile, with proportionately more in the younger age cohorts. As in England, community nursing reports the oldest age profile of the three groups in NHS Scotland. One in three nurses working in the NHS community sector in Scotland is aged 50 or older. The recent review of nursing in Northern Ireland also raised concerns about age profile and relatively high imminent retirement rates in midwifery and in mental health services, amongst<sup>23</sup> other sectors.

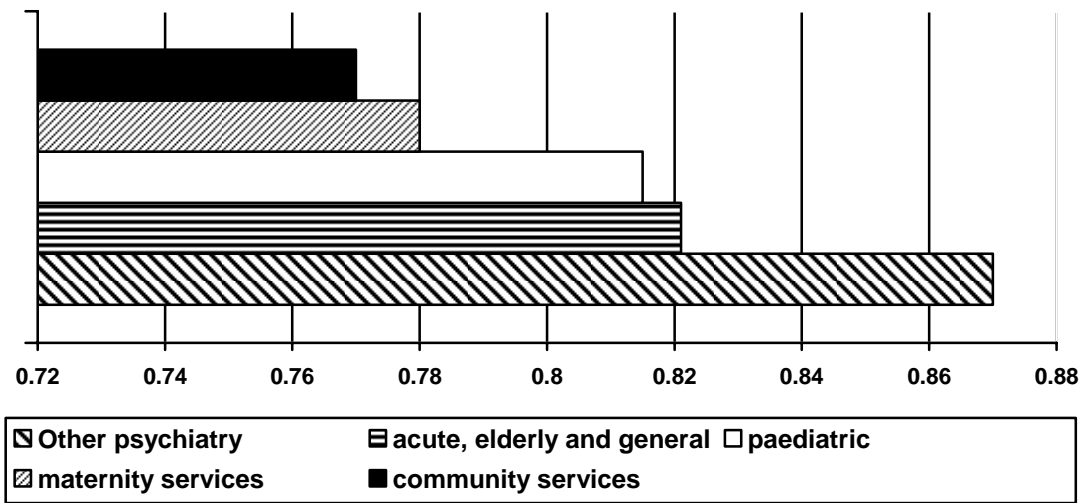


Source: Ball and Pike/ RCN, 2007

The RCN membership survey conducted in 2007<sup>24</sup> gave further evidence of varying age profiles in different sectors of nursing (see Figure 27). Based on a survey across all four UK countries, the findings highlighted that practice nursing had a markedly older age profile- almost one in five practice nurses were aged 55 plus, whilst NHS acute reported a younger age profile.

Another factor which is related to age is the average hours worked by nurses. Figure 28 below shows the whole time equivalent (WTE)/ headcount ratio in different areas of work. Of the five main areas of work for NHS qualified nurses in NHS England, community services reports the lowest ratio. In other words, of the five areas, nurses in community services work, on average, the fewest hours, and have the highest proportion of part-time working. Gender differences and working patterns will play a part in explaining these differences, but the fact remains that community services currently require proportionately more staff to reach each staffing WTE than do the other work areas.

**Figure 28: WTE/ headcount ratio, qualified nurses, NHS England, selected areas of work, 2007**



Source: The Information Centre

Note: a ratio of 1.0 would mean all nurses worked full time – the lower the figure, the lower the average number of hours worked per nurse.

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<sup>25 26 27 28</sup>. 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.

**Planning and managing the move to community**

The Darzi report has reinforced and added momentum to the policy intention to shift resources, care delivery, and staff to community/ primary care and away from acute care. Generally this issue has been given insufficient 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 is also a sector that is currently relatively more highly dependent on part-time staff – so replacement is not just a question of when one full-time nurse leaves, a new full-time nurse is recruited.

There has been one recent national assessment (in England) of the workforce implications of shifting care to community settings. In November 2007 the Workforce Review Team initiated a review to evaluate issues around the development of the workforce for primary care services<sup>29</sup>. The review conducted key stakeholder interviews and scenario modelling. One finding from interviews was 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).

Five possible future scenarios were modelled under different assumptions about skill mix change and employment levels. The review concluded that the demand for primary care services is likely to grow substantially in the medium term, that more GPs will probably be needed to meet this demand (unless a radical change in skill mix occurs) 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 is ageing and the capacity of the system to fast track newly qualified nurses into primary care is growing slowly.

Another, regionally focused, workforce strategy for shifting care to the community has also recently been published. The workforce strategy for London<sup>30</sup> sets out some of the key changes identified within NHS London to achieve a Darzi future. *Workforce for London* outlines the need for an overall increase in the size of the NHS workforce in London, better trained staff based out of hospital and increased investment in improved training and education, including a relative shift in funding towards continuing professional development. One suggestion is that it would lead to 1,500 additional community nurse posts being created<sup>31</sup>.

The strategy also attempts to give some directional targets for change in workforce location from acute to primary care. It notes that currently most staff in London deliver care in a hospital setting, but that that the proportion of doctors and nurses providing care in a non hospital setting over the next 10 years will increase significantly:

- 25% of doctors are currently based in a community setting; this will increase to 47% over a 10 year period
- 22% of nurses are currently based in a community setting; this will increase by 18% to 40% within the next decade.

The strategy also notes that education and training of the next generation of clinicians will need to properly reflect the leadership and clinical skills required to deliver these new models of care, and that “There will need to be a significant increase in the numbers of nurses, paramedics, midwives and health care scientists, such as biomedical scientists” 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 practitioners<sup>32</sup>.

In combination, these two recent reviews highlight projections for substantial growth in NHS primary/ community care/ practice nursing, and development of a broader mix of staff in primary care, as the result of policy led changes in service delivery and funding. The WRT report does highlight some of the possible workforce constraints on achieving these changes. In terms of the nursing workforce, both the NHS community sector and the practice nurse population is older and more reliant on part-time staff than the NHS acute sector. Training and education are not currently configured in such a way as to enable fast tracking of significant numbers of new nurses direct to primary care, and older nurses from acute care to primary care.

Growing the community/ primary care and practice nurse workforces is not just a simple matter of recruiting direct from the acute sector or direct from UK training, or from international sources. The skills base required to work in the community is different; the traditional career path has been for nurses to work first in the acute setting then move into community nursing or practice nursing – hence the older age profile<sup>33</sup>. At the time of this report, an attribute list of community nursing skills is being developed by a Department of Health led team in England<sup>34</sup>. In Scotland the NHS is piloting a new service model for community nursing, including the development of a new community health nurse role, which is intended to absorb common elements of district nursing, public health nursing (health visiting and school nursing) and family health nursing. A project to test the proposed new service model in four NHS development sites is at an advanced stage<sup>35</sup>.

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. In this context, international recruitment has not been a useful tool to enable staff growth. Most internationally recruited nurses who work in the NHS are working in hospitals and relatively few countries train nurses in the skills and qualifications required to move straight to a NHS

community/ primary care post. The UK will have to look to its own resources to build up the primary care nursing workforce.

Recent research for the Scottish government<sup>36</sup> has reported that there is considerable scope for nurses to work in advanced roles in community care as part of supporting the shift in balance of care. The research highlighted three reviews that reported evidence that nurses in advanced roles may increase or improve services; the report also noted that there are significant gaps in the evidence base, including research on the impact of unpaid carers and the role of social workers.

### **In conclusion...**

In recent years the LMR has documented the decline in availability of the data sets required to effectively plan the nursing workforce and test the impact of policies. This trend has not yet reversed.

The *Next Stage Review* highlights a shift in the focus of NHS workforce planning in England, and a policy driven move to greater use of community based care. There will also be a need to evaluate the impact of a shift to all graduate entry for nurse education. Yet the information base on which this revised planning process will have to rely is weak, fragmented and eroding.

The new Centre for Excellence which is intended to play a lead role in supporting workforce planning and policy will inherit an incomplete data base on the nursing workforce, with many critical gaps. This raises a question of how it can aspire to planning excellence with the current poor data foundation. With the exception of the Electronic Staff Record (ESR) data being analysed by the Information Centre –which should give scope for improvements in the assessment on nurse job moves, absence etc. – there are no other positive signs of change in the availability of necessary data on the nursing workforce, indeed there are signs of continuing weakness (see Box 1 below).

The new centre should have scope to bring together the key data-holders: the NMC, universities, private sector employers as well as the NHS itself, in order to make the necessary improvements to the data base on the nursing workforce. A new structure for NHS workforce planning will be incomplete, and is likely to fail, if there is no improvement in the information on which it is based.

**Box 1: What the Centre for Excellence will need to know – but won't...**

What we need to know:	<i>The reality</i>
1) We do not have accurate comparable UK wide attrition rates during pre-registration nursing and midwifery education.	<i>Critical for effective commissioning. Yet despite a common definition being agreed in England for measurement, there is currently no complete and comparable data. Northern Ireland has agreed a new measurement system with HEI from Sept 07. Attrition rates calculated in Scotland.</i>
2) We do not know with any accuracy how many newly qualified nurses and midwives take up employment in the NHS or elsewhere.	<i>No improvement. Has been made more problematic because of changes in student indexing (new initiative underway in Scotland to enhance data about students).</i>
3) We have little published evidence of the actual retirement behaviour of nurses; a vital issue given that so many are in the 50 plus age group.	<i>Issue of vital and growing importance, particularly in community care, practice nursing and nursing homes sector, yet no improvement.</i>
4) We have no accurate knowledge of how many of the overseas registrants are actually working in the UK, or where they are based.	<i>No improvement. 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 out of date.</i>
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.	<i>No improvement in published information.</i>
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.	<i>Has worsened. Return to practice data no longer collated at national level in England. Office of Manpower Economics (OME) survey has reducing response rate</i>
7) We do not have consistent or complete information on vacancy rates across the four countries to assess the impact of shortages.	<i>No improvement; and more questions being asked about relevance of “point in time” three month vacancy rate.</i>
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	<i>One area of improvement- Information Centre analysis of ESR data gives scope for new information. Other source, the OME survey, has</i>

<b>and destinations of nurses leaving the NHS.</b>	<i>reducing response rate</i>
<b>9) We have only scant information about the dimensions of the growing non-NHS nursing labour market and the flow of nurses between the NHS and other nursing employment.</b>	<i>Vital for effective planning and commissioning at SHA level in a “mixed economy” of providers, yet worsened. Data currently not published nationally in England. This will be a core requirement for effective commissioning and planning in NHS England.</i>
<b>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.</b>	<i>Attempts at improvement, but changes in definitions, and large “unknown” response rate limit utility of data. NMC does not publish data.</i>

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