Royal College of Nursing response to the Health Education England (HEE) consultation on *Facing the Facts, Shaping the Future* - A draft health and care workforce strategy for England to 2027

A consultation to inform the Workforce Strategy that will be published in July 2018 to coincide with the NHS's 70th birthday.

Key recommendations

- The UK is experiencing a nursing workforce crisis[i] and the demands on the health and care system are rising and growing more complex. The nursing profession is uniquely placed to help develop a system fit to meet these demands, but recruitment and retention must urgently be addressed, with appropriate investment.

- The RCN welcomes this consultation on developing a workforce strategy. It is long overdue and essential to solve the current nursing workforce crisis. However, the present draft consulted on here does not contain what is needed for our health and care services either now or for the future.

- A real workforce strategy needs a whole-system approach, that sets out what is required by way of workforce, based on population needs, what levers will be used, and how implementation of a strategy will be supported. We call for a real whole system approach that looks beyond the health arms-length bodies to co-develop a meaningful strategy that:
    - sets vision
    - establishes models of partnership working
    - sets out the workforce we need, policy levers and funding, and
    - designates clear approaches for implementation and monitoring.

  Effective local and national delivery will require complex partnerships. This needs cross-Government leadership which brings all relevant departments and/or agencies together for a coordinated approach within each health and care system, as well as across the UK.

- A methodology to determine and respond to population-based demand and need for the nursing workforce, in the context of the evidence base, must be central to a credible strategy. The Health and Social Care Committee agrees, stating that "future projections of need for nursing staff should be based on demographic and other demand factors rather than affordability" and, referring to the draft strategy, that "the methodology behind these projections is not clear."[ii] This includes the need for mandatory data collection across all sectors of the existing health and care workforce, irrespective of who is providing services.

- The current draft strategy focusses almost exclusively on the NHS. Yet, increasing numbers of nurses do not work in the NHS. It therefore only captures a small part of the picture and which will significantly affect the success of a strategy. This strategy should be designed for the health and care workforce, together.

- Whilst health is a devolved matter and this draft strategy has been developed for England, there must be coordination and harmonising of strategic approaches across the countries of the UK, given the cross-border flows of staff and patients.

- The strategy should be supported by primary legislation which clarifies Government, national and local accountability for nurse staffing for safe and effective care in all health and care services. This is fundamentally critical for patient safety. While legislation won't alone fix the extent of the demand and supply problem in the workforce, there is a need for law on staffing for safe and effective care for ensuring the right nursing staff, with the right skills, are in the right place at the right time in Government-funded and taxpayer-funded services. This includes clarifying accountability and responsibility for workforce strategy, policy, planning and funding at every level – including Ministerial ownership, as well as national agencies and any provider of services.

- A workforce strategy must set out to secure the correct supply of suitably qualified staff to meet future service demand and population needs. Degree-educated registered nursing posts should remain adequate in number to deliver safe and effective nursing care as this reduces risk to patient safety and delivers improved patient outcomes.[iii] While we support new supplementary routes into the nursing workforce being created in England, such as the nursing degree apprenticeship and the nursing associate role, it is critical that registered nursing posts are not substituted with lower-level non-registered nursing staff. This should never be driven by cost savings. Any decisions about workforce should always begin with the requirement to ensure patient safety, as well as to deliver safe and effective care.

The key workforce issues for nursing

1. The UK is experiencing a nursing workforce crisis with a range of alarming evidence demonstrating this.[iv] For the first time in years there are now more nurses and midwives leaving the profession before retirement then joining, with 27% more nurses and midwives leaving the register than joining.[v] Since 2012/13, 8,000 nurses have left social care.[vi] One in three nurses are due to retire within the next ten years.[vii] The impact of the EU referendum appears to be driving nurses from the EU away.[viii] The Care Quality Commission has raised safety concerns relating to nursing shortages.[ix] The new education funding model in England is failing to resolve this crisis for now and the longer term.

2. The population and its demand for more complex healthcare continues to grow without sufficient acknowledgements or action on ensuring that both strategy and funding address demand and need. Meeting these needs will require greater integration of acute and community care, prioritising prevention as well as treatment and harnessing the possibilities of developments in technology. Nurses are uniquely placed to manage this change the health and care sector needs. They work across the patient journey, from diagnosis to discharge and deliver full episodes of care to the patient. Increasingly, nurses are diagnosing, prescribing and leading multidisciplinary teams, leading quality improvement, service design and commissioning. Research has shown that among many other things, nursing care contributes to notable decreases in hospital readmission[x] and improved delivery of quality care[xi]. When sufficient numbers of registered nurses are present, mortality rates reduce, quality improves and patients report better overall satisfaction.[xii]

3. Yet, nursing recruitment and retention are in severe crisis. Early indications are that the new education funding model of tuition fees and loans for nurse training is proving ineffective: the reforms have not led to the anticipated increase in nursing students[xiii]. In fact, in some areas student numbers have declined - for example overall applications from mature students, and declining numbers for specific fields of learning disability nursing and mental health nursing.[xiv] Overall, applicants to nursing courses had fallen by 33% in January 2018 since the same time in 2016.[xv] This runs contrary to the Government's aspiration to grow the pipeline supply of the future nursing workforce through this policy.[xvi]

4. There are key ingredients for workforce retention including continuous professional development (CPD), pay and wider development opportunities that must be invested in if the nursing shortage is to be resolved, according to the Health Select Committee.[xvii] These will enable clear career progression and support the profession to meet the new pre-registration standards set by the regulator, the Nursing and Midwifery Council (NMC), as well as improve care for a higher number of people with increased complexity of needs and co-morbidities in acute and community settings.

5. The current approach to workforce planning in England is fragmented and incomplete, with no clear national accountability for ensuring that nursing staff with the right skills arrive in the right parts of the health and care system at the right time. This is supported by evidence from the Health Foundation, having reviewed the guideline based approaches in the NHS in England and comparing with other UK countries and internationally, the Health Foundation have concluded that the current approach to the development of safe nurse staffing guidelines risks irregular and incomplete application and is compromised by the lack of an evidence base for the methodology.[xviii]

6. To successfully secure sufficient supply of staff, the workforce strategy first must have a whole-system approach that sets out what is needed by way of workforce, what levers will

be used and how implementation of a strategy will be supported. Most urgently, a methodology to determine and respond to population-based demand and need for the nursing workforce must be developed and central to the strategy. The Health Select Committee in its recent report agrees, stating that "future projections of need for nursing staff should be based on demographic and other demand factors rather than affordability" and, referring to the draft strategy, that "the methodology behind these projections is not clear."[xix]

7. Boosting arbitrary numbers of health workers is not sufficient for real workforce planning and in addition to supply (production of workforce, i.e. how workforce becomes available, where it comes from and how it enters the sector/labour market), forecast efforts should be based on:

    - Demand (number of workers, skills and distribution in current and future healthcare services and systems; determined by fiscal parameters, i.e. the current and future allocations by Government)

    - Utilisation (how services are used; e.g. A&E attendances, bed occupation, caseloads, waiting lists);

    - System requirements and objectives (types of services, i.e. promotive, preventive, curative, rehabilitative and palliative services; shift in the demand for patient-centred care, community-based health services, and personalized long-term care); and

      Needs (population demography, epidemiology, treatment developments).[xx]

8. Evidence[xxi] shows that in order to be effective, projection of workforce requirements in healthcare must:
    - Use an approach that is consistent with the objectives of the health care system;

    - Derive workforce requirements from service requirements and those service requirements are aligned with system objectives; and

    - Consider workforce requirements in the context of production functions for health services (i.e. other types of human and non-human resources, such as facilities, equipment, and medications), amongst other things.

    Regarding the first point, it is important to understand that this means that if the primary objective is meeting population health care needs[xxii] failure to plan for workforce according to those needs while using supply-based approaches only will perpetuate and exacerbate existing inefficiencies and inequalities in these systems.

9. The Organisation for Economic Co-operation & Development (OECD) undertook a substantive review of health workforce planning models across 18 countries in 2014. [xxiii] Some of the models examined have used needs-based models to provide better estimates of current and future health workforce requirements based on population need. These models try to factor in new criteria such as unmet care needs to improve estimates of future provision. Nursing is the main point of focus in the examples of Australia, Canada, France and Germany and these and similar approaches should be examined by HEE for developing the right needs-based model for the strategy for England (see Appendix 1 for more detail).

10. There are a range of different methods to determine population need used in these four examples, which might inform a methodology for England:

- Assuming the supply and demand of health workers are in “balance” in a reference year as a baseline to project future demand from;

- Using demographic profiles of the population (size and structure), level and distribution of health and illness and the quantity and mix of health services required for individuals at different levels of health and illness;

- Using data on self-reported health status (from population-based surveys) and health service utilisation indicators;

- Projecting the rise in hospital admissions and the number of persons needing long-term care in different settings; and

- Applying basic nurse-to-population ratio approaches, based on population projection estimates.

11. We note that in the past, the Centre for Workforce Intelligence (CfWI) was tasked with delivering workforce planning advice across in England. The CfWI attempted some supply and demand-modelling to project the supply and demand of the nursing workforce in England in 2013.[xxiv] They used nurse registrant data and modelling techniques to project supply and demand based on a set of scenarios. The methods to determine demand included working to meet Quality, Innovation, Productivity and Prevention (QIPP) targets and responding to the growing demographic burden with efficient preventive measures such as effective management of long-term conditions to keep people out of hospital. We are not aware that any further attempts have been made at establishing population need for healthcare.

12. Training and recruitment must be invested in for strategic growth of the domestic workforce, which is currently in decline. In the short-term, international and EEA recruitment must be maintained to meet the immediate existing shortage. At the same time, domestic training must urgently be strategically monitored and incentivised. Stakeholders and the House of Commons Health Select Committee agree that the fastest and most effective route into registered nursing is through higher education[xxv] and there are existing unused opportunities, such as fast-tracking graduates through a postgraduate route. These options will also grow the workforce at a quicker pace than new vocational routes take. (See Question 2 for more detail).

13. The health and care workforce works across the whole health and care system, including the independent sector. A true England-wide strategy must cover this full scope, or it would risk implementation on the basis of an incomplete picture which would be wholly ineffective. This will also need to include coordination and harmonising of strategic approaches across the countries of the UK, given the cross-border flows of staff and patients.

Consultation questions

1. **Do you support the six principles proposed to support better workforce planning; and in particular, aligning financial, policy, best practice and service planning in the future?**

1.1 Yes, we broadly support the intention behind these principles, however they are currently lacking in the detail needed to make robust workforce decisions and do not currently provide useable metrics for measuring impact.

1.2 Patients, carers and the public are missing from these draft principles. The primary focus of the strategy and of the principles should be on delivering high quality and safe patient care for improved outcomes.

1.3 As it stands, the document and the principles within it do not represent a strategy. We would expect a strategy to contain a vision, milestones and accountability. The principles should outline a clear vision for the future workforce and highlight which bodies are accountable for delivery of this vision.

1.4 The principles should carry forward into the structure and contents of the strategy, which should set out the plans for implementation, costings and clear accountability.

1.5 These principles are currently too NHS focussed and should be made inclusive of the whole care pathway, applicable everywhere that care takes place including local authorities and independent providers. The need for greater integration of health and social care is not endorsed in these principles.

1.6 High quality evidence, data and engagement with stakeholders should underpin all future workforce decisions and must be reflected in the strategy principles. This warrants a specific principle, as well as methods to base implementation on evidence and engagement woven into the whole strategy.

Retention of staff should be made a key priority in these principles, and possibly warrants a principle of its own, for example: ***"Staff working in health and care settings feel valued and secure, and supported to remain in their profession"***

1.7 More detailed comments are set out in our response to each specific principle below.

Principle 1: Securing the supply of staff

1.8 We agree with the sentiment behind the first principle but it does not currently provide a meaningful metric from which to make effective workforce decisions. We are experiencing a workforce crisis, in the nursing workforce 27% more nurses are now leaving the profession than are joining.[xxvi] Nursing staff report that due to workforce shortages they can no longer do the work they love to a standard that is acceptable to them.[xxvii] We must move towards a population needs-based approach to workforce supply and planning, and principle 1 should endorse this approach.

1.9 This principle is also non-specific in terms of the makeup of those "staff" it is not simply enough to ensure the supply of staff, these must be the right staff with the

appropriate skills mix to meet population needs. The evidence is clear on the paramount importance of the right skill mix for patient safety.[xxviii]

1.10 The more appropriate term for 'staff' is 'workforce'.

1.11 We suggest a clearer wording which indicates a measurable target, for example:

"Securing the supply of the right workforce with the right skills in the numbers required to meet future population demand"

Principle 2: Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff

1.12 We welcome a principle setting an intent to invest in training and new workforce entrants, particularly in light of recent reductions to the Workforce Development budget, primarily used for CPD and specialist training, and the fall in applications to nursing degrees since the removal of funding for pre-registration education.

1.13 As set out by the Health Select Committee, essential factors for workforce retention must also be invested in if the nursing shortage is to be resolved[xxix], including CPD, pay, wider post-registration training and career development opportunities. These are essential to career progression, and the profession must also be supported to meet the new pre-registration standards, as well as improve care for a higher number of people with increased complexity of needs and co-morbidities in acute and community settings.

1.14 The requirement for a flexible and adaptable workforce that can undertake varied roles and responsibilities across the heath and care system is a core focus of approaches, such as Sustainability and Transformation Partnerships (STPs) or Integrated Care Systems (ICSs), which seek to better integrate health and care provision across specific geographical areas. STP/ICSs are relying on the flexibility, capability, and goodwill of nurses and other staff to deliver their proposed changes. These proposals imply potentially significant changes to the employment terms and conditions of nurses and other healthcare staff, who will be required to work across different locations, sectors or even organisations, as well as potentially being asked to take on new and additional responsibilities. Nurses and other registered professional staff should not be placed in a position that when undertaking more 'flexible and adaptable roles', they could be putting their professional position with their Regulator at risk. While these changes could offer positive opportunities for staff, there is a real risk to pay and conditions – particularly when there might be a change of employer or where staff are working in roles that cover numerous employers or service providers, e.g. NHS organisations, Local Government, GPs and independent sector employers. Any potential impact on terms and conditions of employment (including pension provision) need to be considered at the earliest opportunity and not left to the end of a process. In our work within the NHS Staff Council and in our work with independent sector employers we firmly value the 'Partnership' approach – this needs to underpin any discussions about changes to employment or working patterns or responsibilities. If changes are made solely on the basis of saving money they run the risk of creating unsafe nurse staffing levels and skills mix.

1.15 We are alarmed by with the wording that sits underneath these principles, “blending clinical responsibilities.” We would instead suggest an approach that recognises the need for flexibility and collaboration without undermining the integrity of the distinct professions, for example “facilitation of greater collaborative working and acknowledgement of competence and autonomy.”

Principle 3: Providing broad pathways for careers in the NHS

1.16 Career development is essential if we are to develop the flexible workforce needed to meet current and future workforce demands. To meet the challenges of an ageing population with increasingly complex health care needs more health and care staff must be equipped to work at the interface of acute and community care, skilled in prioritising primary and secondary prevention as well as treatment, and are kept up-to-date with developments in technology.

1.17 It is unclear why this principle has been limited to the NHS only, when the workforce strategy is intended to sit across the whole health and care system. There is a need for a career pathway that facilitates greater integration of acute and community care, health and care, NHS and independent sector and this principle must reflect this.

1.18 We suggest a re-wording which reflects the need for flexibility in career pathways which allow for alternative routes to career progression across the health system, for example:

“Providing broad flexible pathways for careers in health and care”

1.19 There must be equity across health and social care professions, which currently is not the case: compared to nursing, other professions, such as paramedics, physios and pharmacists, either start on Band 6 or progress to this after a period of preceptorship.

1.20 Career opportunities outside of acute care settings must be promoted. An RCN survey in 2017 looked at older people’s care as a career choice, and highlighted several suggestions for encouraging more nurses to consider a career in care homes. These included making changes to both undergraduate and postgraduate education programmes that better reflected this type of nursing, and the development of a career pathway for those wanting to work in the sector. This will need to include high quality, well-supervised placements in the independent sector to expose students to independent settings.

1.21 Clinical governance arrangements should support flexibility across settings, for example through competency sign off by NHS staff visiting care homes, cross-sector clinical supervision and reflection, open access to NHS training for independent sector nurses as well as rotational post between the independent sector and NHS.

Principle 4: Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare

1.22 Again, we would question why this principle has been limited to the NHS only and suggest that the principle should be re-worded to include the whole health and care landscape, including publicly-funded independent sector provision.

1.23 This principle gives no indication as to how widening participation should be achieved and does not provide a metric to enable measurement of progress. With the removal of funding for pre-registration education and training, we have seen a fall in the diversity of applicants to nursing courses, for example, at January 2018 applicants aged over 25 have fallen by 42% compared to the same time in 2016.[xxx]

1.24 We must ensure that government strives towards wider participation in health professions across the career landscape. While we welcome the introduction of new support roles such as the nursing associate role, the promotion of this role must not result in a two-tiered system based on individual background, and there must be meaningful opportunities to advancement for all individuals who are suitable and interested. As the nursing associate (NA) role is fully implemented across the system, it must be ensured that NAs can progress to registered nurse (RN) status as easily as possible.

1.25 In education more widely, recognition of prior learning (RPL) arrangements to support individuals with experience gaining a degree must be as fair, consistent and affordable as possible.

1.26 The currently proposed introduction of tuition fees for postgraduate nursing students is particular concerning for widening participation. Postgraduate students in particular are more vulnerable to the introduction of fee loans: 64% of postgraduate healthcare students are aged over 25, compared to only 18% of students generally. Women are largely attracted to the healthcare postgraduate route and they represent 80% of the population. There is a higher percentage of ethnic minority students on postgraduate healthcare courses (28%) compared to the general population (14%). The Department for Education equality analysis clearly states that these groups are known to be more debt-averse.[xxxi] Introducing loans is likely to undermine recruitment of this cohort and represents yet another missed opportunity to grow the nursing workforce at a time of severe shortage.

1.27 The career pathways resource the RCN is producing collaboratively with HEE, working with a range of other stakeholders will be of use here. The project has arisen from the following drivers:

- Shape of Caring document which outlined the need for a clear career pathway for nurses and midwives;
- Current policy context, where perceived lack of career opportunities and lack of information for nurses contributes to attrition; and

- Feedback from RCN members: there is a lack of information for nurses and prospective nurses about possible career pathways, career planning tools and career guidance.

1.28 The resource will be applicable UK-wide and based on the four pillars of nursing: education, clinical, research and leadership and management. The project's main output will be an interactive online tool, which will benefit:

- Those who are interested in pursuing a career in nursing;
- Current nurses who wish to map out a career pathway, or change direction;
- Career advisers; and
- Commissioners.

It will also provide guidance on standards as to what an employer or patient can expect from someone in a variety of nursing roles.

Principle 5: Ensuring the NHS and other employers in the system are inclusive modern model employers

1.29 We agree with this principle. We explain what we understand by this in the relevant sections below.

Principle 6: Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested.

1.30 We welcome this focus on workforce implications of future policy decision making. It is vital that these assessments are made through meaningful engagement with all relevant stakeholders such as health and care staff, providers, royal colleges and education providers. This should already be existing practice. It poses a risk that STP plans, for example, have so far largely failed to provide the necessary level of detail around workforce plans or financial assumptions that is needed to allow for proper analysis and challenge. Similarly, the nursing associate role has been developed without appropriate testing and evaluation. The introduction of tuition fees for nursing students has moved these students in to the remit of the Department for Education, making healthcare education a cross-Government issue that requires cross-Government coordination. We would suggest the following re-wording:

"Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested by evidence-based assessments and engagement with stakeholders."

2. Do you feel measures to secure the staff the system needs for the future can be added to, extended or improved, if so how?

2.1 There is currently no strategic approach to funding and delivery of nurse training in England. The education funding reform has removed a substantial incentive to train with nothing put in its place and no monitoring of the impact of this reform on the workforce. Early indication is showing that this policy is proving ineffective: the reforms have not led to the anticipated increase in nursing students[xxxii]. In fact, in some areas student numbers have declined - for example overall applications from mature students, and declining numbers for specific fields of learning disability nursing and mental health nursing.[xxxiii] Overall, applications to nursing courses have fallen by 33% since the same time in January 2016.[xxxiv] This runs contrary to the Government's aspiration to grow the pipeline supply of the future nursing workforce through this policy.[xxxv]

2.2 There are three distinct actions that must be taken to reverse this trend:

- A national communications campaign for nursing;
- Targeted funding for undergraduate pre-registration students; and
- Strategic postgraduate pre-registration programme initiatives.

2.3 The Department of Health and Social Care must lead a sustained high-profile national communications campaign for the nursing profession to ensure that as many applicants as possible are encouraged to apply, train and graduate as nurses through higher education – the continued fall of applications to nursing courses in 2018[xxxvi] makes this ever more pressing. Given the significance of this agenda, and that university degree is the main route, we ask that the Department of Health and Social Care to take the lead on this campaign, retaining accountability and responsibility for delivery. We want the Department of Health and Social Care to consider co-production of this campaign with the Department for Education alongside the Office for Students as the new HE sector body. We note that NHS England are working on a national campaign on raising the perception of nursing and midwifery, which is focused on the existing workforce, children and young people and political influencers

2.4 HM Treasury and the Department of Health and Social Care must provide targeted funding for potential students into undergraduate pre-registration routes and dedicated investment in nursing students. The Government must actively incentivise entry into nursing education immediately through the adoption and funding of targeted incentives. We recommend that this is one of the specific actions Government takes in light of continued falling applications, as requested by the Health Select Committee in its recent report.[xxxvii] The introduction of fees for nursing and other health care students is estimated by the HM Treasury to equate to a saving of £1.2 billion.[xxxviii] It is unclear where and whether this funding has been reinvested.

2.5 Financial support for living costs to incentivise a wider range of applications could take the form of: universal grants for students in recognition of their placements; means-tested grants to maintain diversity; and/or targeted support for parents and carers. For a local targeted approach, a central funding pot could be created within the Department of Health and Social Care. Employers could access this pot to receive dedicated funding to incentivise and grow the required workforce in their area, for example through tuition fee write-off or stipends in recognition of service. The RCN has submitted costed options to the Government to increase the supply into the nursing workforce (see Appendix 2) and other key stakeholders have acknowledged the need for such incentives.[xxxix] The workforce strategy must also contain targeted initiatives to better understand and

address the issue of retention, in line with HEE's RePAIR project work on reducing attrition and improving retention.

2.6 The Department of Health and Social Care and Health Education England must invest in postgraduate pre-registration routes and developing the current workforce. The postgraduate pre-registration route offers a significant policy opportunity to grow the workforce. Introducing loans is likely to undermine recruitment of this cohort and represents yet another missed opportunity to grow the nursing workforce at a time of severe shortage. Given both the numbers and the quality of graduates via this route – with significant contributions to the research and leadership cadre, the Department of Health and Social Care and Health Education England urgently investing in this route will bring real and immediate benefits. As well as graduates of other subjects, strategic initiatives that target people who already work in the health care system, recognising prior learning and enabling progression to degrees and registration are critically important. Not only might such initiatives – deployed at scale – play a key role in meeting the demand for a clinical workforce, they also widen participation in these professional courses. This is a core mission of higher education, a stated aim of the Government, and can also bring significant benefits to the diversity and quality of the workforce.

2.7 Education providers [xl] estimate that many postgraduate pre-registration courses could expand by around 50% if more funding were available. They also estimate that funding tuition costs for these programmes at the 2018 fee rate for undergraduate studies (£9,250 per year) and providing a modest student bursary of £7,500 per student per year towards living costs, would significantly support programme expansion. The total cost of this through a two-year postgraduate route would be £33,500 per student. This is less than the average annual premium paid by trusts over a single year for a full-time equivalent agency nurse.

2.8 Data availability, both for across the existing workforce and for current student numbers, is poor. The 2016 reform of healthcare education funding removed all statutory workforce reporting by Health Education England (HEE) in the form of Higher Education Institutions (HEIs) reporting their healthcare student numbers. There is currently no official and publically available monitoring of numbers of nursing and healthcare students.

2.9 UCAS is providing application and acceptances data for B7 Nursing on an extraordinary basis only in 2017 and 2018. They are doing so only because of the reform, do not ordinarily provide subject-level data in cycle and it is unclear whether this data will be available in future. Higher Education Statistics Agency (HESA) data on student numbers is currently only available with an 18 months' time lag. This means that the most current student numbers are not publically available to assess and plan future workforce supply for health and care services. This must be urgently remedied. The new HE regulator Office for Students and the Department of Health and Social Care must be responsible for mandated data monitoring and collection: For staffing levels of taxpayer-funded services, such as health care services, there must be statutory requirements for workforce data collection across the whole health care sector and at a sufficient level of detail and granularity**.** The Health Select Committee is clear that this requires "a nationally agreed dataset to enable a consistent approach to workforce planning and an agreed figure for the nursing shortfall."[xli] This should also include the latest available student applications and student number data, to enable meaningful and responsive workforce planning. The setting up of the new higher education regulator Office for Students provides a timely opportunity to establish a statutory requirement for this data. For this, cross-Government leadership of the strategy is essential.

2.10 We are supportive of broad and flexible routes into nursing, including apprenticeships. We know that from the initial experience of nursing associate training that many HCSWs wish to become RNs, but are prevented from doing so due to financial reasons and a lack of confidence. We need to ensure that there are alternative routes into nursing for those that cannot take out a traditional undergraduate degree.

2.11 If the Government intends that apprenticeships become a substantial workforce contributor, it needs to ensure that the route is taken up by all employers across the sector. This will require communication from the Government and system-side bodies on how the levy can be used, and how employers might pay for the costs arising in the apprenticeship model (such as costs for salaries and backfill) and should include additional investment. In the case of the nursing associate, national development of and communication about the role is also urgently required, in line with Health Select Committee recommendations.[xlii] With the minimum time for a nursing degree apprenticeship being four years, policy narratives should reflect that this route will not deliver the numbers the service needs by not distracting from the main undergraduate route into the professions.

2.12 Developing the existing healthcare support workforce holds the biggest potential for meeting increasing workforce demand.[xliii] Strategic initiatives that target people who already work in the health care system, as well as graduates of other subjects, can support fast and flexible routes into the profession. This can be achieved through recognising prior learning and enabling faster progression through undergraduate and postgraduate nursing degrees and registration. This is an underutilised route. Not only might such initiatives – deployed at scale – play a key role in meeting the demand for a clinical workforce, they also widen participation in these professional courses. They could also bring significant benefits to the diversity and quality of the workforce.

2.13 We provided Government with a costed model for training healthcare support workers to a graduate level qualification in almost the same time and cost required to educate a nursing associate (see Appendix 2). Northumbria University, for example, runs a course for 20 students seconded from a local Trust on an 18 months course at a cost of approximately £12,000 per student. In contrast, Government is providing £13,500 per trainee nursing associate per 2 year programme.[xliv] Given the overwhelming evidence on the benefits of registered nurses for patient outcomes, the same amount of money would be invested with even greater return in pre-registration programmes.

2.14 Employers need to work closely with HEIs and other training providers to ensure that the student experience is positive and seamless from HEI to practice. The capacity of the system to provide clinical placements must be considered in this strategy. Degree and nursing associate apprenticeships come on-stream at the same time as undergraduate training numbers are planned to be increased will increase the pressure on the system to provide high-quality clinical placements. CPD is also of paramount importance here: the new NMC pre-registration education standards will significantly raise the bar of nurse training and be implemented from next year on. Existing staff must have access to CPD to update their skills so they are able to mentor and supervise students under this new regime.

2.15 To increase workforce flexibility in nursing, nurses must be supported to progress into advanced practice in a seamless manner. This means removing barriers such as funding, job planning and lack of career pathway across all settings. Advanced level nursing practice (ALNP) credentialing allows nurses to gain formal recognition of their level of expertise and skill in their clinical practice, their leadership, their education and their research in a way that is recognisable to colleagues, employers, patients and the

public. The RCN has set a standard and definition for advanced practice and developed the ALNP credentialing programme which launched in May 2017. The criteria include:

- Master level qualification
- Health assessment formal qualification
- NMC recordable Independent prescribing
- A verified job plan that demonstrates current advanced level practice
- Clinical reference
- Transitional arrangements until 2020 for those working at advanced level but without a full masters qualification

To date over 200 nurses have accessed the service and there are over 160 nurses on our public facing directory of nurses recognised in advanced level nursing practice.

3. Do you have comments on how we ensure the system is effectively training, educating and investing in the new and current workforce?

3.1 We have commented extensively on the current failure to effectively train the new workforce in Question 2.

3.2 In order to address the shortage and improve retention, nurses must have access to essential conditions such as pay, opportunities for improved flexible working arrangements, CPD and wider career development opportunities. [xlv] Skills development is essential for ensuring that the existing workforce are kept up-to-date with the new pre-registration standards, as well as improve care for a higher number of people with increased complexity of needs and co-morbidities in acute and community settings. Flexible working is not just about access to part-time working. It is fundamentally about how you ensure that your staff, in all their diversity – can access employment and can do this in a way that enables them to deliver high quality care. This could mean part-time work for some people but for others it may mean ensuring that reasonable adjustments are in place for them to be able to attend work or to be safe in work.

3.3 National funding for CPD, for nurses working in the NHS, is provided through the HEE budget for workforce development. This includes specialist learning at diploma, undergraduate and postgraduate degree levels and stand-alone modules. CPD is crucial to ensure quality and safety through the workforce having the skills it needs to perform respective duties, in particular in areas where highly technical and advanced knowledge is required, for example burns areas. Budgets for CPD for nurses have been substantially cut in recent years – 60% over the past two years, from £205m in 2015/16[xlvi] to £83.49m in 2017–18. In contrast, the 'future workforce' postgraduate medical and dental budget will be increased by 2.7% in 2017/18.[xlvii] The Health Select Committee reports the detrimental effect this is having on the existing workforce.[xlviii] Investment in advanced nursing is essential to ensure that health and care services are transforming to meet changing population health needs and demographics.

3.4 Similarly, post-registration training is badly affected. All specialist post-registration training programmes were under-recruited against HEE's 2016–17 Workforce Plan. The programme group, as a whole, was under-recruited by 22%. Health visiting training recorded the largest under-recruitment, with a shortfall of 34%.[xlix] Health visitors have specialist skills that enable them to support new parents and babies at the most critical

period of their development. In recognition of this vital role, health visiting training received a brief period of investment in 2011 with the Health Visitor Implementation Plan. This plan set out to invest in more health visitors as a response to low numbers coming through training, and to bolster the capacity of the workforce to deliver essential health promotion activities for babies, children and families.

3.5 The Department of Health and Social Care (DHSC), HEE and employers must all work together to unlock extra placement capacity in the system to deliver the volume, type and quality of work-based clinical placements required for pre-registration nursing students, apprentices and training for nursing associates. This must be accompanied by additional funding to support learning in practice and to train and maintain a sufficient number of assessors and mentors. This includes resolving the lack of CPD funding for registered nurses, in line with the Health Select Committee's clear recommendations.[i] Given the increased expectations for pre-registration education, as set out in the new draft Nursing and Midwifery Council education standards and framework, the existing workforce must be upskilled to support and work alongside the next generation of nurses.

3.6 The content of CPD needs to be carefully decided and directly aligned to the current educational needs of the healthcare workforce. It is essential that the career aspirations of individual nurses are taken into consideration with service needs. In order for CPD to be effective, it needs to be developed collaboratively by employers and universities when delivered by external providers. Much of the provision could be delivered through work-based learning, formal courses are not the only way to learn. This work-based learning would help to establish communities of practice and learning organisations and might include the following:

- Clinical supervision and reflection - both tools that can be used very effectively to support informal learning;
- Action learning sets; and
- Revalidation, as this can support lifelong learning.

3.7 There is also a need a better online learning offer for all staff, which must be interesting and easy to access and use, including the development of applications for mobile devices.

3.8 Areas where no high quality education exists for existing workforce need to be identified and inter-professional education encouraged wherever possible. In the future, knowledge of and skills in genomics, technology, sustainability, public health, leadership and management will be increasingly required by all nurses and this must be prioritised by HEE in the development of this strategy and corresponding future funding allocations.

3.9 CPD education should support nurses to carry out their roles and enable them to transition across specialities and clinical/practice settings. It must be of a consistent quality and standard across all education providers. The use of Recognition of Prior Learning must be made easier in terms of academic consistency, cost and ease of access. It is also essential to evaluate all CPD to ensure good value for money and that any programme results in better patient/client care.

3.10 Nurses are increasingly extending and expanding their scope of practice beyond initial registration in all health and care settings. In areas such as general practice and community health, acute care, sexual health and mental health, nurses are now commonly working at an advanced practice level. Advanced practice is a level of practice, rather than a type or specialty of practice. Advanced practitioners are educated at Masters-level in clinical practice and are assessed as competent in practice, using expert knowledge and skills. They have the freedom and authority to act, making autonomous decisions in the assessment, diagnosis and treatment of patients.[li] We have set the standards for Advanced level nursing practice and the new apprenticeship model aligns to these. The education and infrastructure required must be sustainably funded and workforce strategies to ensure equity (e.g. multi-professional rotas – one example is *Urgent and Out of hours care*-career framework, see Q 6.4).

3.11 Public health training for the workforce needs funding, especially the delivery of making every contact count. Local authority funding continues to be cut, for example 59% have cut smoking cessation services. There is a need for more discussion on prevention; how prevention of ill health needs to be built in to workforce plans, where the workforce consider public health and prevention strategies and linking up services better together in context of the integration agenda.

4. What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?

4.1 In order to recruit and retain staff at all levels it is essential to ensure that they have access to careers advice and, if necessary, to mentors and coaches. It is also essential to develop a career pathway resource to ensure that all nurses and potential nurses have the correct information to plan their nursing careers.

4.2 As mentioned earlier the RCN working collaboratively with HEE to develop a career pathways resource to support clarity of information for the workforce around potential career planning. This will need to be supported by education and training investment to ensure that potential can be realised.

4.3 It is currently far too difficult for nurses to move across and between settings and specialities – there needs to be more flexibility and support from employers to enable this to happen, including the acknowledgement of transferable skills.

4.4 In line with the above, this will require robust workforce planning with high quality data to review and predict the demand for the nursing workforce. Sufficient staffing, investment in pay, terms and conditions, CPD and career pathways that allow nursing staff to:

- Have sufficient time to provide the right level of care, working in environments with the right number and configuration of staff
- Experience their work to be ‘good work’ and ‘safe work’
- Keep up to date with new developments and improve their skills
- Get full support through the transition to and development in managerial/supervisory roles

- Benefit from high quality appraisals and ongoing support which are proven to boost staff engagement
- Progress in their clinical careers without feeling forced into managerial roles
- Meet their work-life balance needs
- Feel valued in their work and through their levels of pay, terms, conditions and pensions
- Improve and protect their health, wellbeing and safety
- Benefit from workplace protections and partnership working within the workplace between employers and employee representatives; trade unions and professional bodies
- Know that their voice is listened to at all levels in the organisation and that their trade union and professional body is an equal partner in any partnership arrangement.is
- Be actively involved in service improvement.

5. Do you have any comments on how to better ensure opportunities to; and meets the needs and aspirations of; all communities in England?

5.1 The Equality Act 2010 places a coherent duty on public sector bodies. The Public Sector Equality Duty (PSED) requires the relevant organisations to have due regard to the need to:

- Promote equality of opportunity;
- Eliminate unlawful discrimination, harassment, victimisation and other conduct that is prohibited; and
- Foster good relations between those with protected characteristics and those who do not in all areas of their work. In the first instance, there must be clear and unequivocal assurance that these responsibilities are being met and mainstreamed into the core business of the sector.

5.2 The strategy should outline the dimensions of the culture change needed to create inclusivity across the health and social care. We recommend five areas for focus in this regard which are outlined below and seek to create a system-level step change towards inclusion which enables the sector to better meet the needs and aspirations of all communities.

5.3 Accountability: The strategy should be able to pinpoint a clear point of focus and remedy for staff and their representatives when organisations consistently fail to deliver on their equality duties as a minimum. Many individual organisations and employers are uncommonly powerful when it comes to shaping the experience of their employees beyond issues of pay, terms and conditions. Yet few appear willing or able to leverage inclusion as part of a wider solution to tackling deep-seated inequalities within the domain of workforce. Evidence from Workforce Race Equality Standard as well as anecdotal information from RCN members strongly suggests the failure of the health care sector to adopt and use inclusive workplace practices results in potentially wasteful, destructive and workplace cultures and behaviours that fail to make constructive use of the diversity of health care sector. There should also be a clear and costed commitment to reviewing the infrastructure across the sector to ensure that it can deliver on these basic standards. Inclusion and inclusive workplace practices need to be firmly designed into structures, processes and policies with clear and sustained support given to staff at all levels to understand and implement and embed the changes.

5.4 Leadership: We suggest that more needs to be invested into front-line learning, and support development in this area, particularly with respect to accredited representatives and moving beyond existing legislation to create clear protections for Equality Reps. The strategy should also provide for sustained investment in building the capacity of those with formal responsibility for leadership. In this regard, we would recommend further exploration of the work of the NHS Leadership Academy and the Building Leadership for Inclusion initiative. In essence, the strategy should promote and sustain models of collective leadership across the sector.

5.5 Narrative: Beyond formal policies and processes lies the deep narrative of the NHS and the lived experience of the staff and teams that work. The health and social care sector will be required to provide a credible narrative about why so-called non-traditional communities invest time and resources in the sector. The narrative should be compelling and persuasive enough to offer a credible counterpoint to shared narratives of those with lived experiences of ageism, homophobia, sexism, transphobia and racism amongst a wide range of other issues that health care staff face. In essence, the strategy should also focus on the imperfections within the health care labour market and take clear and decisive steps to design out bias and unfair discrimination at all stages of the employee journey from initial attraction, recruitment, and retention.

5.6 Voice: Increasingly our lives are complex and ever-changing and it is important that employers design workplaces and care settings that understand and respond positively to the changing circumstances of their employees. Lack of flexibility remains a key reason that forces some health care professionals into untenable situations where they are required to choose between work and 'life'. It is therefore important that the strategy recognises the complexity of staff experiences and the fact every single health and social care sector employee will have at least three protected characteristics that help to shape and define their life chances at any given time. Understanding the intersectionality of experience and life chances offers an opportunity to redesign jobs, entry and exit points career pathways, cultures, processes, systems and career breaks and total reward packages that reflect this plurality. The dimension of voice also represents an opportunity to strengthen and deepen partnership working across health trade unions who often enjoy the trust and confidence of diverse communities across England.

5.7 Finally, there should be a focus on the metrics. The strategy document should focus on how the voices and aspirations of health and social care staff can be used to create a powerful and salient set of metrics that measure what truly matters to this group.

5.8 Clear assurance of the implementation of the above can be a significant step in ensuring that NHS workplaces attract and develop a diverse mix of people at all levels and promote inclusive cultures.

5.9 Inclusive cultures ensure that jobs fit to people rather than the other way round, where working patterns, environments, management support and access to training are designed to adapt to different needs and circumstances.

5.10 Our costed initiatives (Appendix 2) include means-tested dedicated support for nursing students and extending the existing hardship fund to ensure that everybody who wants to become a nurse has the opportunity and support to do so. In light of the introduction of the apprenticeship route into nursing, equality of opportunity for access to graduate-level programmes at universities must be ensured for all groups.

6. What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?

6.1 It is important that all employment issues are considered and developed by the current NHS partnership structures such as the NHS Staff Council and Social Partnership Forum (SPF). The Staff Council has responsibility for maintaining the Agenda for Change pay system (including the Job Evaluation system and the Knowledge and Skills Framework) and negotiating any changes to terms and conditions of employment. The SPF has responsibility for ensuring positive, diverse and inclusive workplace cultures in NHS organisations, where staff are developed to meet their potential and pursue a career in the NHS. In addition, the NHS Pay Review Body has clear responsibility for making recommendations on any annual pay award, national Recruitment and Retention premia and High Cost Area Allowances for Agenda for Change staff. There are many challenges faced by the AfC workforce including an ageing workforce, stagnating wage levels, declining morale and motivation, and increased staff shortages leading to spiralling workloads and pressures. Through improved connection and alignment between these partnership bodies, as well as increased resources, their work could release workforce capacity and improve productivity.

6.2 The Staff Council is currently undertaking a review of Agenda for Change and the RCN is clear that its aims for this review are to improve the pay structure so that it is simpler to explain, understand and operate and so that it is fair and affordable for now and the future. Through RCN and joint staff side evidence to the Pay Review Body we have also called for an above inflation pay rise to bridge the cap that has opened up and progressively widened between NHS pay levels and the cost of living since 2010 to fairly reward and retain staff.

6.3 Improved pay also needs to go hand in hand with attention paid to the psychological contract – how employees are treated and involved – the 'conditions' element. There is a great deal of evidence to show how morale and motivation in the NHS workforce are being undermined by working pressures, working hours, organisational culture and targets, feeling undervalued by managers, violence and bullying. Attention to and action on these issues must be achieved through coordinated national and local activity through the Staff Council, national partnership forums and employing organisations in order to promote a healthy and safe workplace. The workplace must be such that it not only retains its workforce but is attractive to new staff wishing to enter it. As we have stated earlier the work environment should be flexible enough to support all the diverse employment needs of the workforce. Nurses and care assistants are predominantly women and this will remain the case for the future. There needs to be an environment that welcomes flexible working, provides sufficient support and access to a career for women returning from maternity leave. It should be sufficiently flexible enough to be able to create roles that compliment an ageing workforce while at the same time showing a clear career path for new entrants. Of course this does not all have to be about 'employment' many nurses value the ability to work flexibly through Bank and agency working. This can also help the health provider in that they are able to 'flex' their workforce to the demands they face we would support the use of flexible working arrangements that deliver fair pay for this group nurses and care assistants.

6.4 Across organisations co-ordination and collaboration to ensure portfolio careers[lii] are achievable and effective. Portfolio careers provide variety in careers and aid retention

and development of staff. They also help provide specialist practice across a range of clinical settings to ensure a safer patient journey. Examples of good organisational practice are mandatory training passports, payroll alignment and job planning. Workforce oversight boards need to be empowered to make this the norm rather than exception.

6.5 Multi-professional rotas are becoming common in advanced practice. Collaboration and co-ordination is required to ensure there is a reduction in variation and adoption in localities. The new *Urgent and OOH 111* career framework[liii] is a good example of multi-professional working with career opportunities for nurses, doctors and other AHP.

7. Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?

7.1 Staffing levels for safe and effective care are paramount to guaranteeing excellent care. The evidence is clear on the importance of the right staffing numbers and skill mix for patient safety.[liv] Every registered nurse has an obligation in accordance with the NMC Code to "put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed, and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged."[lv] In addition, registered nurses are required in accordance with the NMC Code to "make sure that patient and public safety is protected. You work within the limits of your competence, exercising your professional "duty of candour" and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate."

7.2 We need staffing shortages addressed urgently. In September 2017[lvi], we analysed data from over 30,000 nursing shifts across health and care settings, NHS and independent providers, in the UK (24,381 in England). 56% of respondents reported a shortfall in planned staffing of one or more registered nurses on their last shift (58% for NHS providers and 25% for independent providers). Respondents reported that they are regularly working additional unplanned time, usually unpaid. In England, 71% of NHS day shifts in adult acute wards reported fell outside the recommended nurse to patient ratio (1:8) standard set out in the NICE nurse staffing guideline for adult acute wards. 26% (1,200) of these shifts had more than 14 patients to one nurse. 36% of respondents said that due to shortages they had to leave necessary patient care undone and over half (53%) said care was compromised on their last shift. This should be taken extremely seriously, as care left undone is associated with increased patient mortality.[lvii]

7.3 We need an approach to developing a national UK-wide approach to determine the size of the workforce needed for a safe and effective health and care system. Local decision making in relation to safe and effective staffing must be informed by national and local legislation, policy and guidance, research evidence, existing professional guidance and in accordance with the NMC code. Providers of health and social care services must ensure that they have the right numbers of registered nurses with the right knowledge, skills and experience, in the right place to provide safe and effective nursing care to patients. Responsibility for the provision of safe and effective staffing lies with the Boards of provider organizations who must have governance arrangements in place that are sufficiently robust to provide assurance that nurse staffing is adequate to provide safe and effective care for patients and clients.

7.4 In addition, there are a number of practical measures providers can undertake:

- Ensuring protected leadership, such as nurse managers, are being supervisory and not in roster numbers
- Effective use of in-house bank systems to reduce the need to use agency staff;
- Flexible extra capacity teams that can be deployed, e.g. deliver one-to-one 'specialling' for patients at high risk
- Any redeployment of staff must ensure appropriate assessment and training to guarantee competency and patient safety
- Leadership and management development opportunities must be available at all levels to ensure a talent pipeline and staff feeling empowered to undertake service improvement. This will require hierarchy and transformational leadership styles in organisations.

8. What policy options could most effectively address the current and future challenges for the adult social care workforce?

8.1 All individuals in the social care workforce should be registered with a professional body. There should be national standards for registration and thus training that go beyond the care certificate (which is no more than a basic induction to care work). All care work and provision should be supervised and managed by a registered nurse in partnership with the MDT, including pharmacists, occupational therapists and physiotherapists and medics. Pay, terms and conditions should be commensurate with and reflect the skills and education required for the work and have parity with all health care colleagues, as part of national standards and negotiating machinery. The RCN calls for real financial investment into social care to offset the reduction in funding over the last seven years and to reflect the growth in demand for care in this sector.

8.2 It is reassuring that some of the challenges and the magnitude and complexity of social care have been recognised, however, all the consultation questions, bar this one, are very NHS-centric. This focus on NHS providers only, is narrow given NHS services provided by other employers and that the NHS is a smaller provider than the sum of the plethora of diverse independent health and social care services.

8.3 The moves to further integration of health and care services, such as through STP/ICSs, are currently too often dominated by the acute care sector. If the potential benefits are to be maximised it is vital that local authorities and other social care providers are fully engaged with these developments.

Unregistered unregulated private carers

8.4 Importantly, the draft strategy makes no mention of care that is provided independently through private means and is therefore not regulated or influenced in anyway. A significant proportion of adult social care in the home is provided by independent care workers who provide personal services through informal or individual employment contracts with clients or their trustees. Free Local Authority-funded care (and thus responsibility) is only available if a person's capital threshold is less than £14,240. Independent carers are commanding direct payments of at least £20/hour[lviii], plus expenses. These carers are not regulated or registered with anyone other than HMRC, and they have no need to produce CRB checks or undertake any training or education. The need for a one million more full time care workers by 2035[lix] raises real challenges

as to the effectiveness of these roles and this needs to be included in the wider workforce strategy for health and social care. These task-focussed roles require oversight and management by community nurses, in order to promote health, wellbeing and independence and prevent acute deterioration and unnecessary hospital admission.

An unnatural divide between social care and health care

8.5 The draft strategy assumes there is a natural divide between what social care needs are and what are health needs, when in reality most of people's personal care needs overlap and require a similarly fundamental level of physical and clinical skill. Conditions that affect independent living in the community and health and wellbeing need to be cared for by an accountable, joined up, properly educated and trained professional workforce.

Particular issues regarding social care in the consultation document

8.6 The divide also means a significant lack of data and transparency in local authority-funded care services and relative accountability held nationally, despite forming part of the same care pathway.

8.7 The introduction of the draft strategy says '*High quality adult social care and prevention services are vital to managing NHS demand'* (para 2, page 68). We challenge this view as too simplistic. It is high quality, joined-up community nursing and health care services that are key to prevention. The only way social care services will prevent ill health, acute admission to A&E, premature death or admission to a care home is by professionalising and educating social care health workers.

8.8 The draft strategy refers to '*frictions between how services link up'* (para 2, page 68) – this is a misnomer as there is no link up between the two, no joint oversight and no joint accountability. This is not a 'friction', it is a lack of single statutory responsibility. Unless commissioners/STPs/ACOs have true and single oversight and we have a staff passport system for staff to work across all sectors, there can be no real integration.

8.9 The draft strategy cites '*turnover is high at over 25%*' (para 1, Page 69). This is an underestimate in our experience, it is likely to be much higher.[lx]

8.10 The draft strategy references the *Horizon 2035: health and care workforce futures* report to evidence increased demand for lower skilled direct care staff (para 4, page 69). It is this very kind of thinking that effective adult social care can be provided by a low skilled care staff, this is the root of many of the current issues and problems. As described above, for care to meet need, facilitate independence and prevent deterioration and acute health episodes, good end of life care, the workforce require a significant level of skill and education.

8.11 The section on 'Employers of choice' (page 70, para 6) refers to low productivity but discusses this no further. It is clear from all the research about the value of higher skill mix and nursing that higher productivity, improved efficiency and better outcomes will be achieved by care provided by a much higher skilled, professionally trained and professionally educated led workforce.

8.12 Similarly, Paragraph 8 on page 70 demonstrates an ignorance by trying to compare the sector with retail, catering and hospitality. Of course these offer employment competition because they may be able to pay more for a lower skill level but the jobs are incomparable. The '*Values based recruitment by Skills for Care'* that helps employers with '*an evaluation'* is a useful tool, however, it exemplifies reactive tasks, rather than more critical proactive nursing assessment and intervention

8.13 Paragraph 1 on page 71 refers to staff leaving to seek career progression – most workers are on or near the National Living wage or National Minimum Wage do not leave the sector for career progression they leave the sector for pay progression within their locality.

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The Royal College of Nursing

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Appendix 1: International models of needs-based workforce planning models

This appendix provides more detail on four needs-based workforce planning models that include nursing from other countries and should be considered in the development of this strategy.

The countries considered in this analysis, the key details of their respective workforce plans, year of launch and period of coverage are:

COUNTRY	YEAR OF PLAN & INSTIGATING BODY	PROFESSIONAL FOCUS	DURATION OF PLAN
Australia	2012; Health Workforce Australia	Doctors, nurses & midwives	2010-2025
Canada	2007; Canadian Nurses Association	Nurses only	2007-2022
France	2011; Ministry of Social Affairs & Health	Nurses only	2006-2030
Germany	2010; Federal Statistical Office	Nurses in long-term care settings	2005-2025

1. Australia[lxi, lxii, lxiii]

Background

Health Workforce Australia (HWA) was established in 2009 to improve national-level health workforce planning and training arrangements. The first reports on health workforce projections, covering all doctors and nurses, were released in April 2012, followed by a report focusing on medical specialty projections in November 2012. These health workforce projections are updated regularly.

Objectives of the workforce model

- Project future workforce demand and supply through scenario modelling and identify gap between supply and demand
- Develop options to close the gap between supply and demand

Coverage: Doctors, nurses and midwives

Disaggregation: Doctors (all doctors and by specialties), nurses (all nurses, and by categories of registered nurses including midwives and enrolled nurses)

How the plan was developed

HWA's projections were based on a stock-flow model on the supply side and a utilisation-based model on the demand side. In 2012, there was only one model for all doctors and three

models for nursing staff (one for registered nurses, one for enrolled nurses and one for midwives).

The 2012 reports recognise the importance of health workforce planning by jurisdiction and sectors, but the work focussed on the aggregate level of demand and supply for all of Australia. HWA used information from the general Labour Force Survey (conducted by the Australian Bureau of Statistics) and the more specific Medical and Nursing and Midwifery Labour Force Survey (conducted by the Australian Institute of Health and Welfare).

The supply of health workers is measured in both head counts and FTE. In the baseline scenarios (referred as the comparison scenarios), the supply and demand of health workers are assumed to be in "balance" in the reference year (2010) for the projection models related to all doctors and nurses.

However, the projection models for the different medical specialties incorporated an assessment of the labour market situation in the reference year, based on the assessments of key stakeholders and using information about waiting times and vacancy rates. These assessments were put in three categories: 1) no current perceived shortages, 2) some level of expressed demand exceeding supply, and 3) perceived current shortages.

In addition to the baseline comparison scenarios, seven alternative scenarios were developed to explore the potential impact of different interventions for the models related to all doctors and nurses. These were categorised in three groups based on the nature of policy options: 1) innovation and reform, 2) immigration, and 3) other impact scenarios.

Results

In the baseline (comparison) scenario, Australia is expected to have a shortage of 109,490 nurses by 2025. These HWA projection models explored three different categories of scenarios that may mitigate or exacerbate these baseline scenarios based on different variables:

1) innovation and reform
2) immigration, and
3) other impact scenarios.

The innovation and reform scenarios include changes that can improve models of care, scope of practice and improved practice (e.g. productivity gain, reduced demand through prevention, and workforce retention). The second category investigated the impact of different levels of reliance on immigration of health workers on the future supply in Australia. The third category assessed the impact of other possible scenarios (e.g. capped working hours, current undersupply etc.).

In each scenario, the number of graduates from domestic nursing education programmes is treated as the 'adjustment variable' (the numbers that are required to achieve a balance between projected supply and demand). The conclusions of this model are below:

		Nurses			
		Supply (FTE)	Demand (FTE)	Gap (FTE)	Graduates Needed[1]
	Graduate levels				12 603
	Comparison scenario	280 442	389 932	(109 490)	23 552
Innovation/ Reform	Productivity gain: 5% increase	280 442	370 435	(89 993)	21 602
	Low demand: 2% below comparison scenario	280 442	311 797	(31 355)	15 738
	Greater workforce retention	367 240	*392 086*	(24 846)	15 088
Immigration	Medium self-sufficiency: reduced to 50% of baseline	260 114	389 932	(129 818)	25 383
	High self-sufficiency: reduce to 5% of baseline	241 819	389 932	(128 616)	27 031
Other Impact Scenarios	High demand due to changing community expectation and other factors	280 442	473 565	(193 123)	31 915
	Undersupply of 5% in the initial year of projection	280 442	402 997	(122 555)	24 859

[1] The number of graduates required annually for the workforce to be in balance in 2025. The increase begins from 2016 for all nurses and from 2018 for physicians.
Source: Adapted from HWA (2012a)

2. Canada[lxiv, lxv]

Background

In 2007 the Canadian Nurses Association (CNA) developed a national planning model focusing on registered nurses (RNs) providing direct clinical care. This model sought to estimate the current supply versus future need of RNs in Canada over a 15-year period.

This model is aligned with federal, provincial and territorial policy which calls for population health needs-based health human resource planning.

Objectives of the workforce model

- Estimate the future requirements for RNs' services based on the size, distribution and levels of health care needs of the population;
- Estimate the future supply of RNs' services based on the size, characteristics of the current workforce as well as trends in entries and exits from the workforce; and
- Assess the effects of different policy options on the supply and requirements for RNs in the short, medium and long term.

Projection Period: 2007-2022.

Coverage: Registered Nurses (RNs) in Canada (excluding nurse practitioners).

Disaggregation: By sector: acute care, long-term care, home care and community care.

How the plan was developed

The supply side of the model was based on a stock-flow approach considering entry (education and immigration) and exit (retirement, death, and emigration). The stock of RNs takes into account the total number of license holders, the proportion of nurses who provide direct clinical care (participation rates) and their working hours (activity rates) to calculate FTEs.

In order to determine the current and future needs for RNs, four variables were considered:

1) the demographic profiles of the population (size and structure);

2) the level and distribution of health and illness;

3) the quantity and mix of health services required for individuals at different level of health and illness; and

4) productivity (interpreted as the amount of health services produced per FTE RN per year).

In order to determine the level of need, the model used a combination of data on self-reported health status (from population-based surveys) and health service utilisation indicators for each sector. Self-reported unmet health care needs were taken into account to estimate the total needs for nurses in 2007. The conclusions of this model are below:

SUPPLY MAPPING:

	Variables	Measurement Approach	Assumptions (baseline scenario)
Inflow	Education	Enrolments	13,000 in 2007, increased by 900 starting in 2010-2011(due to funding increase announced in several provinces)
		Program length	Constant at 3.6 years, the average length of RN education programs in Canada (weighted by program size)
		Program attrition: proportion of entrants who leave the program before completion	Constant at 28%, based on data from 17 schools from 7 provinces
		Graduate out-migration: proportion of new graduates who do not enter practice as RNs in Canada	Constant at 5%, based on data from 3 provinces (British Columbia, Ontario and Saskatchewan)
		New graduates	Determined by enrolment, program length, attrition and graduate out-migration.
	Migration		Constant at 1 023, based on the number of international students who passed the Canadian RN exam in 2007
Stocks	Number of Health Workers	Head counts: number of RNs in Canada *potentially* available to provide nursing services	Number of RN license holders, excluding those who are licensed as nurse practitioners.
	Participation	Participation rate: proportion of all licensed RNs employed in direct clinical care	Constant, at 81%
	Working Time	FTE calculation, based on hours in direct clinical care	Constant, based on data for acute-care RNs in three provinces (New Brunswick, Nova Scotia and Ontario)
	Productivity	Number of service performed per FTE RNs per year, separately estimated for acute care, long-term care, home care and community care.	Constant
Outflow	Retirement and Attrition	Exit rates, by age-specific rates at which RNs cease renewing their licensure	Constant, based on provincial/territorial-level of non-renewal rates (adjusted for interprovincial/territorial migration)

Source: CNA (2009)

DEMAND MAPPING:

Variables	Measurement Approach	Assumptions (Baseline Scenario)
Population	Size and distribution of population by age and sex	Statistics Canada's population estimates
Needs	Acute care: combination of rates of injury and number of chronic conditions, and self-assessed unmet needs Long-term care: combination of 1) individuals already in long-term care facilities, 2) individuals in hospitals waiting for beds in long-term care facilities, and 3) individuals living alone and unable to perform personal care in their homes without help Home-care: combination of met and unmet needs based on self-reported data Community care: distribution of self-assessed general health status	Trends based on past data (e.g. survey data from 1994 to 2005).
Level of Service	The amount of services a person requires by level of need (based on existing level of services) Acute care: combination of 1) the distribution of hospitalization by chronic conditions and injuries, 2) current hospitalization rates by age and sex based on hospital data as well as self-reported data Long-term care: days of care in long-term care per patient per year For home-care and community care: TBD	

Source: CNA (2009)

Results

Taking into account the estimated needs for different types of nursing care, the model estimated that there was a shortage of about 11,000 RN FTEs in Canada in 2007, which includes a shortage of 4,500 RN FTEs in hospitals, 4,500 RN FTEs in long-term care, 700 RN FTEs in home care and 900 RN FTEs in community care. Under the baseline scenario (status quo), the shortage of RNs in all settings was projected to increase to approximately 60,000 FTEs by 2022.

The model also examined the impact of different policy options that might be used to close the projected gaps between the need and supply of RNs. These were:

1) increased RN enrolment by an additional 1,000 students per year from 2009 to 2011 (for three years);

2) improved retention of student nurses by reducing the loss rate from 28% to 15% over three years (between 2009 and 2011);

3) improving retention of practising RNs by gradually reducing the exit rates to 2% for all RNs under 60 year old and to 10% for RNs age 60 and over;

4) reducing RN absenteeism to seven days per year on average (compared with 14 days in 2007); and

5) increasing RN productivity by 1% per year (measured by the amount of services provided by RNs per unit of time).

The model also assessed the impact of reducing immigration of foreign-trained RNs by 50% to increase self-reliance (although this would have the impact of increasing the projected gap).

3. France[lxvi, lxvii, lxviii]

Background

The Directorate for Research and Evaluation (DREES) in the French Ministry of Health developed a projection model for nurses based on a similar model used for doctors. The French nursing profession is less dependent than the UK on overseas recruitment, however there are pressing regional disparities in terms of coverage which the French Government has been trying to address.

Objectives of the workforce model

- To project the supply of nurses in the future and their characteristics
- To provide information on inflows and outflows of nurses during the projection period
- To test the impact of different policies on the future supply of nurses

Projection Period: 2006-2030

Coverage: Nurses who reside and practise in France

Disaggregation: By region and mode of practice (independent, employed by public or private hospitals, employed by retirement homes, or employed by non-hospital establishment).

How the plan was developed

A micro-simulation model was used to consider the graduate transition patterns and the geographic and professional mobility of nurses, building on the results of a previous study that showed differential patterns in education and career paths of practice. It does not take into account foreign nurses entering the French labour market since this is such a small overall number. The model uses a basic nurse-to-population ratio approach on the demand side, based on population projection estimates. The model provides an assessment of the future supply and demand for nurses at both the national and regional level. The conclusions of this model are below:

	Variables	Measurement Approach	Assumptions (Baseline Scenario)
Inflow	Education	Training capacity/student intake	2010 level, constant
		Regional distribution of training quota	Constant
		Gap between the number of graduates and the quota for each region	Average level of 2006-2008, constant
	Entry to Labour Force	Nurse graduates who never enter to labour force	2%, constant
		Timing of entry to labour market	Constant, 99% of those entering will enter in the same year of graduation, 1% in the following year
Stocks	Number of nurses	Head counts (no attempt to do FTE conversion)	
Outflow	Exit	Exit rate for nurses were measured separately for three groups of nurses	• Independent nurses: constant at the level of 2005-2008 • Nurses employed in public or private hospitals: constant at 2007-2008 • Nurses employed outside hospitals: Same exit rate as nurses employed in private hospitals
Mobility	Mid-career changes	Proportion of nurses changing region or mode of practice	Constant at the average of the last years observed (2005-2009)

Source : Barlet and Cavillon (2011)

Results

The baseline scenario is based on the assumption of constant behaviours of nurses and government policies over the entire projection period. It projects that there would be a continuous increase in the number of nurses from 480,200 nurses in 2006 to 657,800 in 2030. The projection model also explores a wide range of alternative scenarios; two of the main scenarios are presented in the table below:

Table 25: Number of professionally active nurses according to different scenarios, 2006-2030, France

		Self-employed	Public hospitals	Private hospitals	LTC	Other	Total
Scenario: employment status reform	**2006**	57 800	237 200	66 000	19 200	100 000	480 200
	2030	117 000	361 400	107 000	27 200	71 500	684 100
	Baseline, 2030	116 100	336 800	106 800	27 000	71 100	657 800
	Difference, 2030	0.8%	7.3%	0.2%	0.7%	0.6%	4.0%
Scenario: Retirement Reform	**2006**	57 800	237 200	66 000	19 200	100 000	80 200
	2030	121 900	348 700	108 900	27 800	73 600	681 000
	Baseline, 2030	116 100	336 800	106 800	27 000	71 100	657 800
	Difference, 2030	5.0%	3.5%	2.0%	3.0%	3.5%	3.5%

Source : Barlet and Cavillon (2011)

These two scenarios focus mainly on the impact of a postponement in the retirement age. The impact of the 2010 reform of the employment of nurses (which increases the retirement age from 55 to 60) would be to increase the number of public hospital nurses by 7.3% by 2030.

The model does not consider the impact of this reform on nursing numbers in non-public settings. The model also calculated that increasing the retirement age still further from 60 to 62 in 2018 would increase the supply of nurses in public hospitals and in all settings by a further 3.5% by 2030.

4. Germany[lxix, lxx]

Background

Projections of the future supply and demand for different nursing professions in Germany were conducted in 2010 by the German Federal Statistical Office and the QuBe project, in cooperation with the Federal Institute for Vocational Education and Training (BIBB) and the Federal Institute for Labour Market and Occupational Research (IAB).

The objective of the QuBe project is to simulate complex interrelations and effects of political decisions and social measures on the national education system and the labour market. In addition to the analysis and results described below occupational mobility was measured for the occupational field 'health care professions without license to practice medicine' and assigned to the nursing professions and its effects were assessed.

Objectives of the workforce model

- Identify possible actions to effectively tackle projected changes in demand for nursing professions

Projection Period: 2005-2025

Coverage: Nurses and midwives (qualified nurses) and auxiliary nurses, geriatric nurses and auxiliary geriatric nurses (nurse aids) working in hospitals, patients' home or (semi-) stationary nursing homes.

How the model was developed

The model uses a duo supply and demand equation (similar to the Canada example). The supply-side focuses heavily on the occupational mobility of nurses including differences between initial qualifications and current posts and different working patterns between regions. The demand-side of the model builds on two earlier studies by the Federal Statistical Office on projected rise in hospital admissions and the number of persons needing long-term care in different settings. The results of the model are set out below.

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SUPPLY MAPPING:

	Variables	Measurement Approach	Assumptions (Baseline Scenario)
Inflow	Education	Those with highest formal vocational qualification in nursing and semi-skilled workers with different vocational backgrounds	Projected upwards based on past education trends and future demographic development. Assumes an increase in the highest qualification attainment that will slow down over the projection period
Stocks	Number of Health Workers	Head count	
	Working Time	FTE calculation	Constant at the current level of • Whole Germany • West Germany • East Germany
Outflow	Exit	Measured by participation rates	
Mobility	Mid-career changes	Comparison between initial vocational training and current posts	Constant

Source: Afentakis and Maier (2010)

DEMAND MAPPING:

Variables	Measurement Approach	Assumptions (Baseline Scenario)
Population	Population projection by age and sex	Central scenario
Utilisation/Need	Probability of being hospitalised and number of people needing nursing care in other settings depending on age and sex	Constant age-sex specific rates of hospitalization or people needing care in other settings

Source: Afentakis and Maier (2010)

Results

This model explored two main scenarios: (1) different evolutions in working patterns and (2) changes in demand (see table below).

Scenario 1 focuses on the differences in the current working patterns between nurses in provinces of the former West and East Germany. The running assumption of health authorities in Germany is that nurses in East Germany are more likely to work full-time, and even when they work part-time, will tend to work more hours compared to their peers in West Germany.

Scenario 2 considers a much more optimistic scenario in which demand for nursing care falls due to people making healthy changes to their lifestyles, diets and behaviours.

Table 28. Alternative scenarios concerning the future supply and demand of nurses in Germany, 2005-2025

	Scenarios
Supply	Constant to the average across all Germany in 2005
	Work patterns are like the ones in West Germany in 2005
	Work patterns are like the ones in East Germany in 2005
Demand	Status-quo: constant age/sex specific hospital diagnoses rates
	Reduced demand: calculated by shifting the current age/sex specific hospital diagnosis or care probability into higher age groups

Source: Afentakis and Maier (2010)

Appendix 2: Incentives to grow the workforce

Options for investment in healthcare education in England

Introduction

This appendix sets out a range of actions for developing and incentivising traditional and non-traditional routes into the nursing and healthcare workforce. It has been submitted as a paper to the Department of Health and Social Care and HM Treasury in 2017.

Background

The 2016 healthcare education funding reform in England moved healthcare students into the standard student support system, now required to access loans. HM Treasury has estimated that this policy decision will be equivalent to a saving of £1.2 billion.[lxxi]

In this paper the term 'healthcare students' is used to refer collectively to nursing, midwifery and dental therapy and hygiene students. It does not include medical and dental students. It also focusses on undergraduate students as this is the majority route into the health and care workforce. There is, however, the significant issue of the ongoing uncertainty about how pre-registration post- graduate students will be funded from 2018/19. Without clarification on this, there is the real risk that the market for, and supply to these programmes will be disrupted, having a significant impact on workforce supply from 2020.

In the context of Brexit and the move to the open market, we think that Government needs to actively incentivise the recruitment of many healthcare more students to meet the growing workforce demand. There is a real danger that the current model of education funding for students will have an immediate detrimental impact on the growth of domestic supply we urgently need in England. We recognise that the investment options outlined in this paper have a cost attached and that this may be challenging within current budgets. However, in the least, this investment will, in the long term, contribute to efforts to reduce spend on agency staff[lxxii]- of which latest forecasts indicate spend totalling approximately £3bn in 2016/17.[lxxiii]

Demographics and education model

These students are fundamentally different from the wider student population, in that:

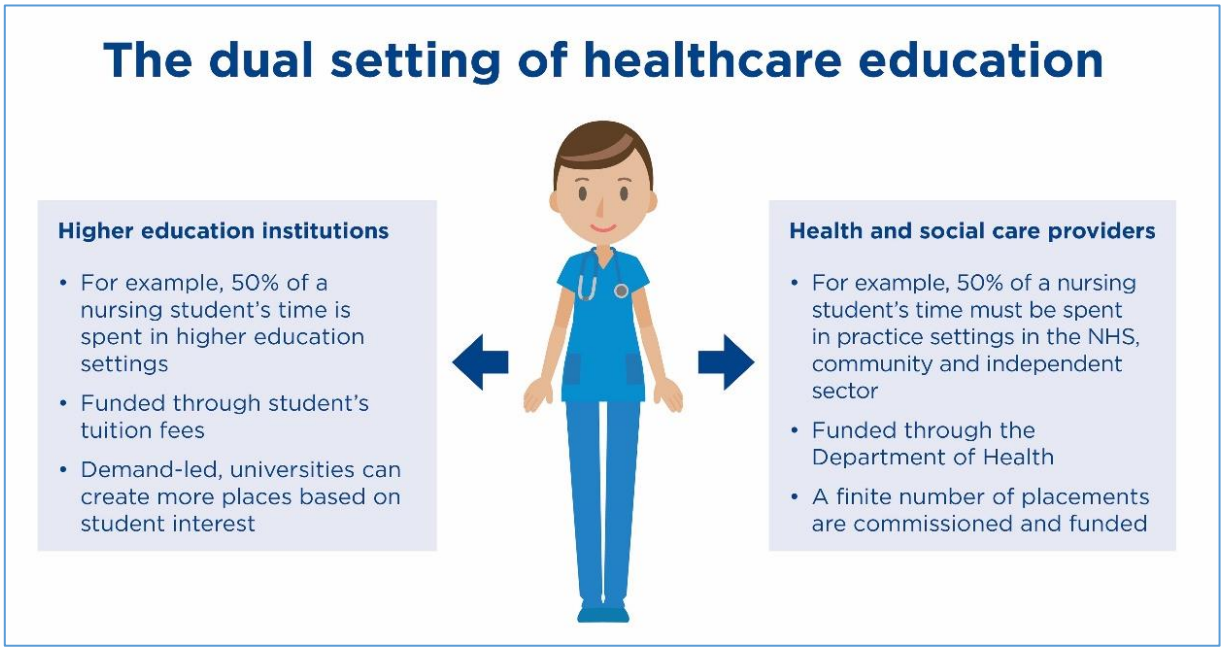
- They are more diverse than other undergraduate groups and more likely to include students from low participation neighbourhoods[lxxiv]
- They are far more likely to be mature students (41% aged over 25, compared with 18% of the total student population)[lxxv]
- They have the highest total workload hours of all higher education subjects.[lxxvi] With 39 weeks per year (and some studying for 48 weeks a year), courses are typically longer and extend beyond the normal university semesters

- They spend up to 50% of their degree on supernumerary[1] placements, making a valuable contribution to the quality of patient care and service delivery across the health and care system while they are learning.

Healthcare students are primarily based at the Higher Education Institute (HEI) at which they are enrolled, but spend up to half of their time in practice-based settings. For nursing students specifically, this means they will pay £9,250 in tuition fees[lxxvii] for their education in the university setting (2,300 hours)[lxxviii], and then spend another 2,300 hours in practice placements across the NHS and social care.[lxxix]

The nature of placements, occurring in blocks of weeks spread across the year rather than within a consolidated period of time, and in a range of locations away from their university base, limits students' opportunities to obtain part-time employment at the same time in order to support themselves. This is unlike all other individual students studying on other campus-only degrees.

The infographic below sets out how healthcare education is split between education and practice.



Growing the domestic workforce

The population of England needs many more healthcare students to meet the growing healthcare workforce demand. After a significant growth in the number of European Union (EU) entrants to the workforce, we are experiencing a drastic reduction in EU entrants, with

[1] Supernumerary status means that student nurses are additional to the clinical workforce and undertake a placement in clinical practice to learn, not as members of staff. This means that students will not, as part of their programme of preparation, be contracted by any person or body to provide nursing care. (Nursing and Midwifery Council, Standards of proficiency for pre-registration nursing education, 2004).

the number of EU-trained nurses and midwives joining the Nursing and Midwifery Council register for the first time dropping steeply since July 2016.[lxxx]

- Recent figures show approximately 40,000 unfilled nurse posts in England as of December 2016,[lxxxi] with the NHS midwifery shortage in England estimated at 3,500.[lxxxii]
- A leaked Department of Health workforce model suggests that the nurse staffing supply in the worst-case scenario could fall by 42,000 after leaving the EU.[lxxxiii]
- England is currently training around 20,000 nurses a year – this number will remain the same for 2017/18.[lxxxiv]
- Government intended this funding reform to enable the training of an additional 10,000 nurses, midwives and AHPs across the course of the previous Parliament.[lxxxv]

Options

We propose approaches which are practicable, building on existing mechanisms and structures. These solutions would incentivise growth in the domestic workforce and are specific, costed opportunities for Government to consider in order to:

- Mitigate potential risks of the healthcare education funding reform and leaving the EU
- Recognise the unique profile and contribution of healthcare students
- Encourage more entrants into the profession.

Given the existing workforce gaps, for safety, effectiveness and quality, and sustainability of health and care services, we ask that Government, HM Treasury and Department of Health consider adopting and implementing all four options. We present the below in order of likely effectiveness and viability.

Option 1: Grants for placements: provides universal direct support to *all* healthcare students

Option 2: Investment in healthcare education through employers: provides the means to significantly pump-prime workforce growth through a local market-led approach, rather than central commissions (and would fully implement the last Government's intention of the healthcare education funding reform)

Option 3: Means-tested grants: ensure that the existing diversity of the student population with regards to socio-economic background and the widening participation agenda is preserved.

Option 4: Targeted support for parents and carers: extend existing hardship funding, supporting what Government has already committed to do to support students with caring responsibilities and those suffering severe hardship. It has been included here as the details of Government's activity have yet to be clarified.

Methodology

Within the following indicative costings the baseline figure used for students includes 20,700 nursing students, 2605 midwifery students, 266 dental therapy students and 53 dental hygiene students, which corresponds to the 2016/17 pre-registration figures as set out in the Health Education England Workforce Plan.[lxxxvi]

These costings are calculated on the basis of the total Department of Health resource DEL for 2017/18, equalling £118.7billion.[lxxxvii] We acknowledge that this DEL contains existing allocations, however, the options present considerable return on investment and wider benefit which merit consideration both within the existing financial envelope, and beyond.

Cost per option are set out per annum and per cohort, i.e. for three years which would allow support for a group of students throughout and including completion of a three-year undergraduate degree.

The four options identified have been costed:

- For the number of students in 2016/17
- For a student number growth of 7%, which we understand is a realistic initial expansion rate
- For a student number growth of 10%, given growing workforce demand

Option 1: Grants for practice placements

Provide dedicated funding for all students in recognition of the time spent in practice placements during degree study

Rationale

- The Government reform of healthcare education funding is an untested and unprecedented move from central workforce commissioning to market-led workforce development in the UK. This poses risks of market failure. Whilst application numbers have been historically high with five applicants to one place for nursing, they have dropped across all the healthcare related professions in the first year of the reform[2] and the number of applicants to nursing places has not expanded significantly compared to previous years in the first week of clearing.[3]
- Critically, the actual number of training places that will be available in the future is not clear. Whilst funding for additional clinical placements has been made available[4], it is not obvious how this will translate into additional training places and whether these will be filled. The additional funding provided is also foreseen to cover additional 10,000 training places only, and it is unclear how this will meet workforce demand.
- Government must find ways to enable training numbers to expand and ensure that they can be filled with domestic trainees in response to identified workforce demand.

[2] UCAS, *Application rates by the January 2017 deadline*, January 2017. Available here. UCAS, *Application rates by the March 2017 deadline*, March 2017. Available here.

[3] UCAS, *Statistical releases – Daily Clearing analysis 2017*, https://www.ucas.com/corporate/data-and-analysis/ucas-undergraduate-releases/statistical-releases-daily-clearing-analysis-2017

[4] Department of Health, *1,500 extra medical undergraduate places confirmed*, August 2017, https://www.gov.uk/government/news/1500-extra-medical-undergraduate-places-confirmed

Providing grants for practice placements would be a key success factor in making this happen, by ensuring that the right numbers enter the workforce.

- In impact analysis of the nursing education reform, Government recognised that practice placements place a particular burden on these students, but the proposed new Travel and Dual Accommodation Expenses fund will only reimburse travel and accommodation costs incurred when undertaking practical training on placements.[5] Full details are yet to be made available. This will therefore not provide a uniform recognition of all students.
- Nursing, midwifery and allied health professional students on courses pre-2017 were eligible for a non-means tested grant of £1,000 per year towards their living expenses along the means-tested allowances when they applied for the NHS bursary.[6]
- This new grant could be defined as recognition of the time already given to the NHS, service delivery settings outside the NHS (within and beyond the public sector), and other practice education settings outside the NHS, while on placement, not payment for work as an employee.

Design

- To recognise and safeguard the supernumerary learner status of students, this should be calculated per student rather than by practice placement setting or hours, to avoid a mechanism that resembles an employment relationship.
- This grant could easily be distributed through Student Finance England and/or the Student Loans Company, alongside maintenance loans, or it could be distributed through the NHS Business Service Authority, which will process the planned Travel and Dual Accommodation Expenses.

Impact

- These comparatively small funds would send a strong signal of Government's recognition, appreciation and value of the future healthcare workforce.
- It would also help to encourage students who carry a financial and/or social burden on to degrees and thereby increase entry into the workforce.

Indicative costing

We have costed this option at the same level of £1,000 per year as the non-means tested element of the former direct student support.

Current student numbers	*+ 7%*	*+ 10%*
2016/17 – 23,624 students £1,000 per year	+ 1,654 students per year (4,962 per cohort)	Extra 10% + 2,362 students per year (7,086 per cohort)

[5] NHS Business Service Authority, https://www.nhsbsa.nhs.uk/healthcare-students/courses-starting-after-1-august-2017

[6] Department of Health (2016) *The NHS Bursary Scheme New Rules: Fifth Edition* available at: https://www.gov.uk/government/publications/nhs-bursary-scheme-rules-2016

£70.9m per cohort for three year degree	£75.8m per cohort	£78.0m per cohort
£23.6m per annum *NB Calculated as 0.020% of DH budget for 2017/18*	£25.3m per annum *NB Calculated as 0.021% of DH budget for 2017/18*	£26.0m per annum *NB Calculated as 0.022% of DH budget for 2017/18*

Option 2: Investment from local employers in return for service[7]

Students receive a stipend or loan/fee repayment from local employers in return for set service within the NHS and other sectors. This would allow local decision-making and implementation in response to local market fluctuations, including potential failure.

Rationale

- The Government healthcare education funding reform has essentially brought the healthcare workforce in line with other sectors, in terms of a market-led workforce supply. There is a real risk to Government that the healthcare education market it is in the process of creating may fail to deliver the required workforce for the health and care system in England – leading to unsafe and ineffective staffing levels in services. Given the critical nature of the workforce to the health system, it is essential that this is mitigated, and Government has accepted this as a suitable approach to such mitigation in other sectors. Creating a central investment fund for local operation will considerably mitigate this risk, allowing local employers and authorities to support the local market as necessary, and enable smooth implementation of the overall reform.
- It is commonplace in other sectors for Government and/or employers to create targeted incentives to encourage entry into the workforce, where domestic supply requires growth. Sponsored degrees with flexible arrangements are available across different sectors.[8]

Existing commitments in teaching

- The Conservative Party manifesto recognised the need to incentivise the teaching workforce and promised to 'continue to provide bursaries to attract top graduates into teaching. To help new teachers remain in the profession, we will offer forgiveness on student loan repayments while they are teaching'[9] Teach First[10] students earn an

[7] We acknowledge that the current apprenticeship model has similarities: however, this is an untested route that does not fast-track workforce development and it will take considerable time still until this new route is fully up and running to produce workforce supply. Further, it is unclear how the practice-based education element is going to be delivered within existing system constraints, which are considerable.

[8] Example sponsored degrees in teaching: http://university.which.co.uk/teachers/introduce-higher-education-options/the-complete-guide-to-sponsored-degrees

[9] The Conservative Party, *The Conservative and Unionist Party Manifesto* 2017, p 51. https://www.conservatives.com/manifesto

[10] www.teachfirst.org.uk

unqualified teacher salary while they train. Teach First has been running since 2002 and positively evaluated.[11]

- The Department for Education provides funding to well-qualified students entering teacher training in priority subject areas that are difficult to recruit to, for example Physics and Maths, students training to be Physics or Maths teachers can access scholarships worth up to £30,000 per year.[12]

Existing commitments in social work

- Step Up To Social Work is an intensive full time postgraduate programme. [13] Trainees gain hands on experience working for a local authority and receive a bursary of £19,833 for the course duration, paid for by their future local authority employer. Once qualified, and if accepted into a social work position, individuals will usually be contracted to spend a period of time with their employer (e.g. 2 years). Step Up has had a positive interim evaluation report, with a high proportion still in the profession three years after graduating and more working in target social work area of child protection than comparator group.[14]

Design

- A central funding pot could be created within the Department of Health that local employers could access to receive dedicated funding to incentivise and pump-prime the locally required workforce growth.
- Students could sign contracts with employers, both in the NHS and other employing organisations, whilst studying and receive financial support in return. This could take the form of fee payments and/or stipends for living expenses, depending on what local employers deem appropriate to meet local workforce demand. The latter will be particularly attractive to students as they offer up front support. It would be essential that students were not tied to a particular post for a length of time, but had flexibility to move between different clinical areas within an employer organisation.

Impact

- This design would accelerate the creation of local market-led, rather than centrally commissioned, workforce development - in line with the last Government's policy. It would also help to mitigate the risk of disproportionate local falls in applications, and thereby mitigate wider risks of the reform.

[11] https://www.teachfirst.org.uk/news/independent-evaluation-demonstrates-positive-impact-our-careers-and-employability-initiative

[12] Department for Education and National College for Teaching and Leadership, *Top graduates to get up to £30k to train to teach core subjects,* https://www.gov.uk/government/news/top-graduates-to-get-up-to-30k-to-train-to-teach-core-subjects

[13] Department for Education*, Apply to 'Step Up to Social Work'*, https://www.gov.uk/guidance/step-up-to-social-work-information-for-applicants

[14] DfE Longitudinal Evaluation of the Step Up to Social Work Programme, September 2017, http://www.bristol.ac.uk/sps/research/projects/current/stepupevaluation/

Indicative costing

This option provides flexibility which would allow local decision-making as to what is required to incentivise local workforce growth as required. We have costed three different incentives that local decision-makers could consider, which are

- A stipend to be paid by employers in return for a contract post-qualification. This has been costed for £12,000 a year, as an example, but would need to be more thoroughly considered in the local context. The teacher training bursaries and funding scales[15] provide a useful orientation here, they range from £3,000 to £30,000 over differing timescales and depending on subjects

Incentive: stipend

Current student numbers	*+ 7%*	*+ 10%*
2016/17 – 23,624 students £12,000 per year	+ 1,654 students per year (4,962 per cohort)	+ 2,362 students per year (7,086 per cohort)
£850.5m per cohort for three year degree	£910.0m per cohort	£935.5m per cohort
£283.5m per annum *NB Calculated as 0.24% of DH budget for 2017/18*	£303.3m per annum *NB Calculated as 0.26% of DH budget for 2017/18*	£311.8m per annum *NB Calculated as 0.26% of DH budget for 2017/18*

- Fee payments in return for contract post-qualification have been costed as a) full fees (£9,250) and b) half fees (£4,625)

Incentive: payment of full fees

Current student numbers	*+ 7%*	*+ 10%*
2016/17 – 23,624 students £9,250 per year	Extra 7% – 1,654 students per year (4,962 per cohort)	Extra 10% – 2,362 students per year (7,086 per cohort)
£655.6m per cohort for three year degree	£701.5m per cohort	£721.1m per cohort

[15] https://getintoteaching.education.gov.uk/funding-and-salary/overview

£218.5m per annum *NB Calculated as 0.18% of DH budget for 2017/18*	£233.8m per annum *NB Calculated as 0.20% of DH budget for 2017/18*	£240.4m per annum *NB Calculated as 0.20% of DH budget for 2017/18*

Incentive: payment of half fees

Current student numbers	*+ 7%*	*+ 10%*
2016/17 – 23,624 students £4,625 per year	Extra 7% – 1,654 students per year (4,962 per cohort)	Extra 10% – 2,362 students per year (7,086 per cohort)
£327.8m per cohort for three year degree	£350.7m per cohort	£360.6m per cohort
£109.3m per annum *NB Calculated as 0.09% of DH budget for 2017/18*	£116.9m per annum *NB Calculated as 0.10% of DH budget for 2017/18*	£120.2 per annum *NB Calculated as 0.10% of DH budget for 2017/18*

Option 3: Means-tested grants

Provide additional support to students from lower socio-economic backgrounds as well as to mature students who may be more debt-averse[16], ensuring equality of access and a diverse student and health workforce population.

Rationale

- Government has recognised that the student population affected is exceptionally diverse, in terms of socio-economic background, age and ethnicity.[17] It is paramount that equality of access is ensured and a diverse student and health workforce population is preserved. We recognise that Government intends to do this through the targeted support for parents/carers and the planned hardship fund, but would urge it to look at wider measures beyond this.

[16] Gorard S, Smith E, May H, Thomas L, Adnett N and Slack K (2006). *Review of Widening Participation Research: Addressing the Barriers to Participation in Higher Education. A report to HEFCE by the University of York, Higher Education Academy and Institute for Access Studies.* York: University of York

[17] DH (2016), Equality Analysis (Consultation stage) *Reforming healthcare education funding: creating a sustainable future workforce,* https://www.gov.uk/government/consultations/changing-how-healthcare-education-is-funded

- Approximately 41% of nursing, midwifery and allied health professional students are aged over 25, compared to 18% of the wider student population.[18]
- A relatively high proportion (37.2%) of all students on subjects allied to medicine are from NS-SEC classes 4,5,6 and 7 compared to most other courses.[19]

- We recognise that the 2012 move to increase tuition fees to £9000 has not had a detrimental effect on the participation of disadvantaged groups. However, we also note that disparities between advantaged and disadvantaged geographical areas remain[20] and that there has been a significant and sustained fall in part-time and mature students applying to universities since the introduction of the new fee regime. Since 2009/10, there has been a 10% drop in full-time mature students.[21] For a Government that has put an increase in social mobility at the heart of what it does, it is essential to consider all measure at its disposal to preserve social mobility where it is already occurring.
- All students entering programmes from 2017/18 have been moved over to a loans system. Currently, the amount of maintenance loan a student is entitled to will depend on household income. If earnings are below £25,000 then the student will be entitled to a full loan, with a sliding scale of means tested contributions towards maintenance for incomes above £25,000.
- Access funding is provided by universities that charge fees that are higher than the minimum level. Such funding is targeted at groups of student who may be put off from attending university. Many universities provide funding for students from low income backgrounds as part of their access agreements.[22] City University London has a bursary for mature students aged over 21 who earn below a salary threshold,[23] for example, and the University of Portsmouth offers a cash bursary of £750 per year to all eligible new full-time, undergraduate students from England whose household income is £25,000 or less.[24] However, the availability and amount of this funding depends on the university and is therefore not universally accessible for all healthcare students. In the context of unmet workforce demand, Government cannot afford to have potential students deterred and must ensure uniform support.

Design

- Students could receive a supplementary grant from DH in addition to their maintenance loan. This could be assessed through the Students Loan Company, which needs to

[18] DH (2016), Equality Analysis (Response to consultation) *Reforming healthcare education funding: creating a sustainable future workforce,* https://www.gov.uk/government/consultations/changing-how-healthcare-education-is-funded

[19] HESA Table SP5 – Percentage of UK domiciled young entrants to full time first degree courses from NS-SEC Classes 4,5,6 and 7 by subject and entry qualification 2014/15, https://www.hesa.ac.uk/data-and-analysis/performance-indicators/releases/2014-15-widening-participation

[20] Higher Education Funding Council for England (2015), *Higher Education in England 2015. Key Facts*. http://www.hefce.ac.uk/media/HEFCE,2014/Content/Analysis/HE,in,England/HE_in_England_2015.pdf

[21] Independent Commission on Fees, *Independent Commission on Fees Final Report, July 2015.*

[22] Office for Fair Access, *Quick Facts,* https://www.offa.org.uk/press/quick-facts/#criteria

[23] http://www.scholarship-search.org.uk/grants/the-city-undergraduate-mature-student-bursary-2015-2016-at-city-university/hc_edufin.page_pls_user_sch_dets/16180339/220707/s/20602087/sch_id/96518/page.htm

[24] http://www.scholarship-search.org.uk/grants/university-of-portsmouth-bursary-at-university-of-portsmouth/hc_edufin.page_pls_user_sch_dets/16180339/220707/s/20602123/sch_id/97968/p_brwback/20602123/page.htm

assess the household income for the maintenance loan for every student. Healthcare students who qualify under the £25,000-threshold could be given additional support.

Impact

- Debt-averse students from lower income backgrounds who may have been deterred from a career in healthcare because of the fee regime will be encouraged, enabling talent to be accessed from people in all areas in our society.

Indicative costing

- Due to data availability, this option is costed for nursing students only. The calculation is based on Higher Education Statistics Agency (HESA) data for all Year 1 nursing students - as defined by JACS codes under B700 and leading to registration with the Nursing and Midwifery Council - in England in 2015/16. These totalled at 18,474 students. 43% of those who gave socio-economic data were in classes 4-7, which have previously been used to identify lower socio-economic backgrounds.
- It should be noted the total number of students with an unknown or not classified socio- economic indicator was 19%, so caution should be exercised when using the above figure in calculations scaled up to the wider student population. We assume that this is due to the relatively high number of mature students who are often direct applicants rather than UCAS applicants. The socioeconomic indicator is mandatory only in the UCAS application.
- The baseline number of nursing students used is as indicated in the HEE workforce plan for 2016/17.[25]

Current student numbers	*+ 7%*	*+ 10%*
2016/17 – 20,700 students[26] 43% receive £750 per year	Extra 7% – 1,449 students per year (4,347 per cohort)	Extra 10% – 2,070 students per year (6,210 per cohort)
£20.0m per cohort for three year degree	£21.4m per cohort	£22.0m per cohort
£6.7m per annum *NB Calculated as 0.006% of DH budget for 2017/18*	£7.1m per annum *NB Calculated as 0.006% of DH budget for 2017/18*	£7.3m per annum *NB Calculated as 0.006% of DH budget for 2017/18*

[25]https://www.hee.nhs.uk/sites/default/files/documents/HEE%20Workforce%20Plan%20for%20England%202016%20180516_0.pdf

[26] Number of nursing students as projected by HEE for 2017/18.

Option 4: The Learning Support Fund

Government has recognised that the distinctive profile of healthcare students with regards to caring responsibilities and potential hardship and will maintain additional financial support to them through the Learning Support Fund.[27] However, the details of this fund, including the amounts available are still unclear.

- We recognise Government's commitment to supporting carers who choose to study a healthcare degree. The Learning Support Fund has been set up to provide financial assistance to students in three areas - child dependants allowance, travel and dual accommodation expenses (see Option 1) and the Exceptional Support Fund.[28] The child dependants allowance and exceptional Support Fund must be easily accessible for students and large enough to support all those in need.
- In its response to the consultation on the funding reform, the Government set out that 'the Department will work with external experts including nursing bodies to develop options to support exceptional cases where nursing, midwifery and allied health students find themselves in severe financial hardship'.[29] We look forward to working with the Department and other relevant stakeholders to ensure the provisions will be adequate. We have costed an estimate for the child dependants allowance part below, based on data availability. We expect the Exceptional Support Fund and, travel and dual accommodation expenses also to be adequate.

Indicative costing

- 20% of students who accessed the NHS bursary had child dependants.[30] The provisions provided following the reform will include a grant of £1,000 per year for students with child dependants.[31]

	+7%	+10%
2017/18 – 23,624 students £1000 per year for 20% of students	Extra 7% – 1,654 students per year (4,962 per cohort)	Extra 10% – 2,362 students per year (7,086 per cohort)
£14.2m per cohort for three year degree	£15.2m per cohort	£15.6m per cohort
£4.7m per annum	£5.1m per annum	£5.2m per annum

[27] NHS Business Service Authority, https://www.nhsbsa.nhs.uk/healthcare-students/courses-starting-after-1-august-2017

[28] NHS Business Authority, https://www.nhsbsa.nhs.uk/healthcare-students/courses-starting-after-1-august-2017

[29] DH (2016), Equality Analysis (Response to consultation) *Reforming healthcare education funding: creating a sustainable future workforce,* https://www.gov.uk/government/consultations/changing-how-healthcare-education-is-funded

[30] DH (2016), Equality Analysis (Consultation stage) *Reforming healthcare education funding: creating a sustainable future workforce,* https://www.gov.uk/government/consultations/changing-how-healthcare-education-is-funded

[31] https://www.gov.uk/government/publications/nhs-bursary-reform/nhs-bursary-reform

NB Calculated as 0.004% of DH budget for 2017/18	*NB Calculated as 0.004% of DH budget for 2017/18*	*NB Calculated as 0.004% of DH budget for 2017/18*

The content in this paper is supported by:

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Non - traditional entry routes into nursing in England

Context

We are currently experiencing a crisis within the existing nursing workforce due to insufficient numbers of registered nurses (RNs), insufficient RN training places (due to practice placement funding), age profile of current RN workforce, high vacancy rates and high wastage rates. Sufficient levels of RNs are critical for the health system to maintain patient safety.[lxxxviii]

In the context of Brexit and the move to the open market in the traditional route to nursing through higher education, we think that Government needs to actively incentivise the recruitment of entrants into the nursing workforce, to meet the growing workforce demand.

We recognise that the investment options outlined in this paper have a cost and that this may be challenging within current budgets. However, in the least, this investment will, in the long term, contribute to efforts to reduce spend on agency staff[lxxxix] - of which latest forecasts indicate spend totalling approximately £3bn in 2016/17.[32]

Growing the domestic workforce

The population of England needs many more healthcare workers to meet the growing demand and needs of the population. At a time of constraint, we are also experiencing a reduction in European Union (EU) entrants to the workforce, with the number of EU-trained nurses and midwives joining the Nursing and Midwifery Council register having dropped steeply since July 2016.[33]

- Recent figures show approximately 40,000 unfilled nurse posts in England as of December 2016,[34] the NHS midwifery shortage in England is estimated at 3,500.[35]
- A leaked Department of Health workforce model suggests that the nurse staffing supply in the worst-case scenario could fall by 42,000 after leaving the EU.[36]
- England is currently training around 20,000 nurses a year – this number will remain the same for 2017/18.[37]
- Government intended this reform to enable the training of an additional 10,000 nurses, midwives and AHPs across the course of the previous Parliament.[38]

[32] Letter to all NHS providers from NHS Improvement on 28 February 2017
[33] Nursing and Midwifery Council, Report on EU nurses and midwives May 2017, https://www.nmc.org.uk/globalassets/sitedocuments/special-reports/nmc-eu-report-june-2017.pdf
[34] The Royal College of Nursing (May 2016), *Safe and Effective Staffing: the Real Picture*, , https://www.rcn.org.uk/professional-development/publications/pub-006195
[35] The Royal College of Midwives, *State of Maternity Services Report 2016*, https://www.rcm.org.uk/sites/default/files/SoMS%20Report%202016_New%20Design_lowres.pdf#page=6
[36] Lintern S (April 2017) *Exclusive: Leak reveals worst case scenario for nursing after Brexit*, Health Service Journal, 6 April 2017. Available from: www.hsj.co.uk/topics/workforce/ exclusive-leak-reveals-worst-case-scenariofor-nursing-after-brexit/7017082.article
[37] Health Education England, Commissioning and Investment Plan 2017/18, https://www.hee.nhs.uk/sites/default/files/documents/Commissioning%20and%20Investment%20Plan%202017-18.pdf
[38] Department of Health (July 2016), *The case for health education funding reform*, https://www.gov.uk/government/consultations/changing-how-healthcare-education-is-funded/the-case-for-health-education-funding-reform

The opportunity

Whilst we recognise that new solutions are required to deliver healthcare to meet current and future population needs, the value of the registered nurse contribution in ensuring high quality patient outcomes must not be underestimated.

The NMC have recently completed a consultation on the changes required to the pre-registration nursing education standards (to enable the future nurse to deliver safe and effective care to meet population health needs). If accepted, the new standards will be rolled out from September 2018. The routes outlined here will remain current, but there could be potential for further development of models for non –traditional routes into nursing.

There are currently four established routes onto the nursing register, which are:

- Degree level apprenticeships for nursing students, which require a minimum of 4 years to complete. These are currently in development and the uptake of these is not yet known and a four year wait for the first cohort to complete is too long given current workforce crisis
- Programmes specifically targeted to Health Care Support Workers (HCSW) to become registered nurses. An example is the Open University programme which offers a route where HSCW can be sponsored by their employer, whilst remaining in employment. However, the employer cost is £27 000 in fees over 3 years, and thus limits numbers who are sponsored through this method.
- Nursing Associate (NA) training will be a potential route into nursing registration and currently this is viewed as being achievable 24 months post NA qualification. There are currently 2,000 trainee NAs in England via a pilot funded by HEE. More are planned for next year, funded through the apprenticeship levy. However the first cohort of NAs will not enter the workforce as registered nurses for another four years.
- Associate practitioners can also use their foundation degree to become a Registered Nurse. However, this often requires a further two years of study to enable them to meet the requirements for nursing registration.

There is potential to complete the routes to Registered Nurse from both the Nursing Associate and Associate Practitioner routes into nursing in 12 to 18 months. However, this would require a change in the current NMC cap of 50% maximum Recognition of Prior Learning (RPL)[39] and in individual HEI approaches to their RPL practices, as HEIs set their own maximum RPL rules. The cost of RPL also needs to be factored into the costings below; each HEI sets their own level of cost for RPL (cost per number of academic credits), with a maximum of £1,000. HEIs may also choose not to charge for RPL, if the student is entering onto a programme of study at that HEI.

Whatever the training route, all RNs must have appropriate education and skills and meet the NMC standards for proficiency at the point of registration and the academic requirements of a nursing degree. Furthermore, there must be sufficient educators with the required skills and knowledge to teach, supervise and assess learners in practice settings.

[39] RPL is the process which recognises skills and knowledge an individual has developed outside the formal education system (or programme) and assesses this against the standards required for a programme to award academic credit.

Options

The current scenario is that simultaneous to the severe nursing workforce deficit, there is now a minimum three year wait for new Registered Nurses to arrive into the system through current training routes.

We propose two practical options to stimulate growth in domestic workforce, through the two quickest routes available. This will help to:

- Mitigate potential risks of the healthcare education funding reform
- Mitigate risks to existing and future health and care workforce in leaving the EU;
- Grow domestic supply through a range of routes;
- Respond to critical gaps within the existing nursing workforce; and
- Encourage more entrants into the profession.

For safety, effectiveness and quality, and sustainability of health and care services, we ask that Government, HM Treasury and Department of Health consider supporting the development and implementation of all options, in collaboration with the RCN.

Option 1: Widen pool of HCSWs to fast track to become Registered Nurses

Rationale

It is possible for employers and universities to work together to develop plans to meet local workforce needs. One existing model is to fast track Health Care Support Workers through 18 months education programmes to become Registered Nurses. This approach incorporates recognition of prior experience through work as an equivalent to study (Recognition of Priority Leaning – RPL). Universities set their own requirements for the proportion of RPL to study, and this is currently capped at 50% by the NMC.

A key benefit of this approach is that it offers career progression. Clarity on opportunities for career progression is essential for employees, employers and universities.

There is potential for wider delivery and take up of this fast track option. There are some local examples of this fast track option being provided, but this is by no means widespread. Given the variation we can now expect due to the new devolved commissioning of nursing education, some method of central oversight for local systems to respond is essential.

Design

There is potential to widen the pool of candidates from the existing HCSW workforce by providing 6 month preparatory training to those who do not yet meet requirements.

The HSCW would undertake an RCN designed and delivered preparatory programme, providing a bridge between their completed HCSW Care Certificate [40] and the Registered Nurse qualification. This preparatory programme would build on the RCN First Steps resource, an online learning resource to support HCSWs develop their practice.[41] The

[40] http://www.skillsforhealth.org.uk/standards/item/216-the-care-certificate

[41] RCN (2017) First Steps www.rcn.org.uk/firststeps

programme would prepare learners for entry into the pre-registration programme, and support them in gathering and presenting evidence for their RPL claim.

This programme would be completed by a HCSW in 6 months (whilst they remain in employment) and will include three modules:

- Introduction to leadership/ developing self
    - 3 days face to face teaching and telephone coaching
- Functional skills and study skills / confidence to learn, leading to certification
    - Online plus 4 hours tutor support
- Professional skills including enhanced communication skills
    - Online plus 4 hours tutor support

The theoretical learning would be achieved through face to face teaching, online learning, including simulation and supplemented by support from a personal tutor. Because this would be based on an individual Recognition of Prior Learning (RPL) claim, the programme delivery would need to be flexible enough to accommodate each individual, depending on their particular learning needs.

HCSWs who have a successful RPL claim, will then move into an NMC approved pre-registration nursing programme. This programme would have to be delivered through an NMC approved education institution (AEI). The outcomes for these programmes are met through 2,300 hours of theory and 2,300 hours of practice, but hours can be achieved through RPL which enables the programme to be achieved within a minimum of 18 months. The practice hours could be a mix of work-based learning and simulation.

Costs for fast track 18 month courses to become a Registered Nurse are individually negotiated between HEIs and local trusts. Employers should be able to pull down from the apprenticeship levy to cover these costs.

Advantages

- Developing the existing healthcare support workforce holds the biggest potential for meeting increasing workforce demand.[42] There are a substantial number of HCSWs who wish to become RNs. They do not necessarily wish to train to become RNs through the traditional university route for financial reasons. The apprenticeship route will not necessarily be available to them until 2018 and would take at least 4 years from then.
- HCSWs will be employees whilst learning and therefore paid during their training
- Would offer a clear means of career progression for HCSWs
- Would support the widening participation agenda and redress the loss of mature students applying for nursing due to bursary changes
- Flexible delivery of specialisms. The existing model for this approach (University of Northumbria) combines generic Nursing Modules and modules specific to the student's chosen field (Adult Nursing, Children's nursing, Mental Health Nursing or Learning Disability Nursing).

Inter-dependencies

[42] Imison C, Castle-Clarke S and Watson R (2016) *Reshaping the workforce to deliver the care patients need*. Research Report. Nuffield Trust.

- Central oversight for local arrangements to ensure all career progression opportunities are being offered, including fast track RPL university course across the country.
- Employers required to ensure that learners are exposed to experience under supervision, in the workplace, to develop their clinical skills, in a variety of settings
- Learners require protected time from employer, in order to study to qualify as a Registered Nurse

Scaling up/ costs

a) Due to the local nature of the existing courses they are not necessarily visible in the higher education statistical data across the system. The below estimate for increased provision is based on the existing course at Northumbria University where 20 students seconded from a local Trust on an 18 months course have been funded with approximately £12,000 per student.

   The cost is calculated on the basis of the total Department of Health resource DEL for 2017/18, which equals £118.7billion. We acknowledge that this DEL contains existing allocations, however, the options present considerable return on investment and wider benefit which merit consideration in the existing budget envelope, and beyond.

20 HCSWs per annum per NHS Trust 189 NHS Trusts	3780 students
3780 x £12,000	**£45.4m** *0.0004% of DH budget for 2017/18*

The current healthcare support workforce within Band 1-4 is approximately 148,094.[43] Some of these will have the qualifications and experience necessary to go on an RPL course already. For those that do not, the RCN would be able to develop a preparatory programme. As there is no official data on this, it is challenging to scale this up appropriately. The costs of an RCN preparatory programme

- Cost per head for the RCN to train each staff member on the preparatory programme is £940.

RCN Introduction to leadership programme	£420 per person
Functional skills	£160 per person
Professional skills	£160 per person
RPL Assessment	£200 per person

Option 2: Expand current funding for MSc conversion for graduates to become Registered Nurses [currently 2 years, but could be 18 months]

[43] https://digital.nhs.uk/media/31870/NHS-Workforce-Statistics-May-2017-Staff-Group-Area-and-Level-xlsx/default/NHS_Workforce_Statistics__May_2017_Staff_Group__Area_and_Level

Rationale

It is currently an option for graduates from other fields to complete an MSc to become a Registered Nurse. The fees for this will be set by universities individually once the current NHS education funding has been removed for postgraduate study. Legislation is needed to move postgraduate (PG) students into the standard student support system, this has only been passed for undergraduates at this point. It is currently unclear when this legislation will be issued and passed. It is therefore expected that relevant PG courses will remain funded by the NHS for 2018 entry.

Due to the current crisis in both Mental Health and Learning Disability nursing, the Nurse First programme is currently being developed for these two fields. The initial cohorts will begin September 2017, comprising just 40 students based in three HEIs.

Given the current crisis in Registered Nurse staffing levels also in adult and children nursing fields, and the three to four year wait for new entrants to graduate from existing routes, we recommend expanding this approach to the remaining two nursing fields. This is needed at this time during which the immediate future of MSc funding is unclear, which is a disincentive for people to consider this route.

In addition MSc pre-registration education for all fields of nursing, outside of an expanded Nurse First programme, needs to be considered.

Design

The Nurse First cohort of students are in paid employment at Band 3 and their university fees paid by the Department of Health. The HEIs reported great interest in these programmes form both potential applicants and employers.

The MSc is currently 2 years, but with flexible use of Recognition of Prior Learning, this could be as short as 1 year (some non-nursing graduates will already be working in health settings). However, this would require a change in the current NMC standards only allowing up to 50% of a programme to be mapped against RPL.

Advantages

- Highly motivated students
- Bring a wealth of previous knowledge and experience
- Lower attrition rates both as student and as registered nurse

Inter-dependencies

- Funding for existing MSc pre-registration programmes in next year is uncertain, need to resolve this immediately to allow recruitment processes to commence for these programmes
- Future funding cannot be accessed through the apprenticeship levy, so would need to be funded in another way
- Current cap of 50% RPL by NMC would need to be amended to enable individuals to qualify in less than 18 months.

- Essential to have high quality placements, with sufficient practice supervisors and assessors need to improve communications around these new routes into nursing for the public and existing workforce. This also requires adequate funding for CPD. RCN could also offer CPD in terms of leadership development programmes, mentorship modules, master classes, both online and face to face modules.

Scaling up/ costs of Nurse First

Cost of MSc course fees approximately per person	£14,500
FTE Band 3 salary for 2 years	£33,936
	£48,436

Scaling up/ costs of MSc route

Costs could be greatly reduced, however, if the students were not paid employees. The costs would then be only the programmes fees and travel expenses for students on placement.

Cost of MSc course fees approximately per person	£14,500
	£14,500

The MSc figure is based on the total two-year cost for the MSc Nursing at the University of Essex. The University of Southampton charges £9,000 per year for its MSc Nursing. Costs at other HEIs are difficult to ascertain at the moment, given that the course is still covered by NHS funding they are not consistently advertised

They were 837 PG on pre-reg nursing courses all fields (all fields, Year 1) in 2015/16 as returned in the Higher Education Statistics Agency (HESA) student record. These were students still funded through the NHS. If these students were to receive the same investment as Nurse First students and the cohort was doubled, costs would be as set out below:

15/16 student number – 837	**£40.5m** *0.0004% of DH budget for 2017/18*
+ 100% = 1680 students	**£81m** *0.0007% of DH budget for 2017/18*

Appendix 1 (non-traditional routes into nursing paper): Content of HSCW Bridging Programme

RPL for practice and/or theory	Indicative content needed to meet degree requirements and ensure adequate study skills against which RPL theory claims would be made	NMC proficiencies to be achieved through experience under supervision and assessment by practice and academic assessor in workplace (draft NMC proficiencies) against which RPL practice hours claims would be made
Employers need to identify potential applicants, and robust selection would be vital to ensure successful outcomes RCN would support with assessment of RPL claim and sign post to resources to meet identified deficits	• Communication • Anatomy and physiology • Pharmacology and medicines management • Public health • Leadership and management • Disease processes • Patient safety • Genomics • Research/critical thinking • Study skills • Literacy (including technological) and numeracy	**Implicit in these proficiencies are the professional and clinical skills required to be a registered nurse** **1 Be an accountable professional** be responsible and accountable for their actions act in the best interests of people, put them first, and provide nursing care that is person-centred, safe and compassionate solve problems and make sound decisions about care for people based on evidence and knowledge. **2 Promote health** take a lead in helping people to improve and maintain their mental, behavioural, cognitive and physical health and wellbeing support and enable people at all stages of their lives to make informed choices about how to manage and improve their current health, and prevent ill health. **3 Assess needs and plan care** assess the health and circumstances of people to inform the need for nursing intervention, care and support take into account the personal situation, characteristics, preferences and wishes of people, their families and carers accept that patients and families become experts in their own care and ensure they have the resources at their disposal to assist them to make informed decisions and that plans for intervention, care and support are tailored to their individual needs and preferences. **4 Provide and evaluate care** take the lead in providing and supervising the delivery of nursing interventions, care and support to people of all ages and in any setting ensure that delivery of all aspects of care is compassionate and safe

		work in partnership with people, families and carers to evaluate whether the goals of care have been met in line with their wishes and preferences. **5 Lead nurse care and work in teams** provide nursing leadership by demonstrating best practice and be accountable for delegating care appropriately to others, including lay carers play an active and equal role in multidisciplinary teams of professionals, collaborating and communicating effectively with colleagues, and with people and families to help them to manage their own care. **6 Improve safety and quality of care** make a key contribution to continually improving the quality of care and treatment given, and improving people's experience of care be able to assess any risks to patient safety or experience, and take appropriate action to manage those, putting the best interests, needs and preferences of people first understand how to manage risks across organisations and settings. **7 Coordinate care** engage with a variety of healthcare and other agencies and professionals, in order to support the delivery of complex care pathways and packages of care.

Appendix 2 (non-traditional routes into nursing paper): Content of MSc pre-registration degree for science graduates

RPL of theory and practice hours	Indicative content needed to meet degree requirements against which RPL theory claims would be made	NMC proficiencies achieved through experience under supervision and assessment by practice assessor and academic assessor in workplace (draft NMC proficiencies) against which RPL practice hours claims would be made
Students with a science degree would clearly be able to RPL relevant theory and those with an arts degree different theory; it is essential that each RPL claim is tailored to the individual Applicants may also be able to RPL practice hours	• Communication • Anatomy and physiology • Pharmacology and medicines management • Public health • Leadership and management • Disease processes • Patient safety • Genomics • Research/critical thinking	**Implicit in these proficiencies are the professional and clinical skills required to be a registered nurse** **1 Be an accountable professional** be responsible and accountable for their actions act in the best interests of people, put them first, and provide nursing care that is person-centred, safe and compassionate solve problems and make sound decisions about care for people based on evidence and knowledge. **2 Promote health** take a lead in helping people to improve and maintain their mental, behavioural, cognitive and physical health and wellbeing support and enable people at all stages of their lives to make informed choices about how to manage and improve their current health, and prevent ill health. **3 Assess needs and plan care** assess the health and circumstances of people to inform the need for nursing intervention, care and support take into account the personal situation, characteristics, preferences and wishes of people, their families and carers accept that patients and families become experts in their own care and ensure they have the resources at their disposal to assist them to make informed decisions and that plans for intervention, care and support are tailored to their individual needs and preferences. **4 Provide and evaluate care** take the lead in providing and supervising the delivery of nursing interventions, care and support to people of all ages and in any setting ensure that delivery of all aspects of care is compassionate and safe

		work in partnership with people, families and carers to evaluate whether the goals of care have been met in line with their wishes and preferences. **5 Lead nurse care and work in teams** provide nursing leadership by demonstrating best practice and be accountable for delegating care appropriately to others, including lay carers play an active and equal role in multidisciplinary teams of professionals, collaborating and communicating effectively with colleagues, and with people and families to help them to manage their own care. **6 Improve safety and quality of care** make a key contribution to continually improving the quality of care and treatment given, and improving people's experience of care be able to assess any risks to patient safety or experience, and take appropriate action to manage those, putting the best interests, needs and preferences of people first understand how to manage risks across organisations and settings. **7 Coordinate care** engage with a variety of healthcare and other agencies and professionals, in order to support the delivery of complex care pathways and packages of care.

The theoretical learning would be achieved through face to face teaching, online learning, including simulation and supplemented by support from a personal tutor. Because this would be based on an individual RPL claim, the programme delivery would need to be flexible enough to accommodate each individual, depending on their particular learning needs. This programme would have to be delivered through an NMC approved education institution (AEI), with 2,300 hours of theory and 2,300 hours of practice. The practice hours could be a mix of work-based learning and simulation.

Endnotes

[i] House of Commons Health Committee. *The nursing workforce*. Second Report of Session 2017-19.HC353.January 2018. https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/35302.htm (accessed 30/01/18)

[ii] House of Commons Health Committee. *The nursing workforce*. Second Report of Session 2017-19.HC353.January 2018. https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/35302.htm (accessed 30/01/18)

[iii] Aiken LH, Sloane D, Griffiths P et al (2016) 'Nursing skill mix in European hospitals: crosssectional study of the association with mortality, patient ratings, and quality of care', *BMJ Quality & Safety*, 15 November, http://qualitysafety.bmj.com/content/early/2016/11/03/bmjqs-2016-005567 (accessed 13/03/18)

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