



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health & Social Care

The NHS nursing workforce

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Department of Health & Social Care

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Report by the Comptroller and Auditor General

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National Audit Act 1983 for presentation to the House of
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Gareth Davies
Comptroller and Auditor General
National Audit Office

3 March 2020

Prior to publication of the delayed NHS People Plan, this report sets out the facts on the scale of the NHS nursing workforce challenge, the main entry routes to NHS nursing and progress made on the NHS People Plan. This report does not evaluate the People Plan process or progress against the published Interim People Plan.

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planning and supply 50

The National Audit Office study team consisted of:

Matt Beaumont, Charlie Bell,
Rosie Buckley, Oliver Evatt,
Claire Hardy, Sue Leveson,
Natalie Low, Michael Woodrow,
under the direction of Jenny George
and Ashley McDougall.

This report can be found on the
National Audit Office website at
www.nao.org.uk

For further information about the
National Audit Office please contact:

National Audit Office
Press Office
157–197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Tel: 020 7798 7400

Enquiries: www.nao.org.uk/contact-us

Website: www.nao.org.uk

Twitter: @NAOorguk

Key facts

5%

increase in overall nurse numbers in hospital and community services between September 2010 and September 2019 (full-time equivalent)

43,590

number of nursing vacancies reported by NHS trusts, July–September 2019 (full-time equivalent)

5%

increase in students starting undergraduate nursing degrees, 2017–2019, compared with target of 25%

38% decrease in learning disability nursing numbers between September 2010 and September 2019 (full-time equivalent)

17% proportion of nursing workforce from outside the UK (headcount, March 2019)

519,000 estimated number of people registered to practise as a nurse in England, September 2019

320,000 number of NHS nurses working in hospital and community services (headcount, September 2019)

What this report is about

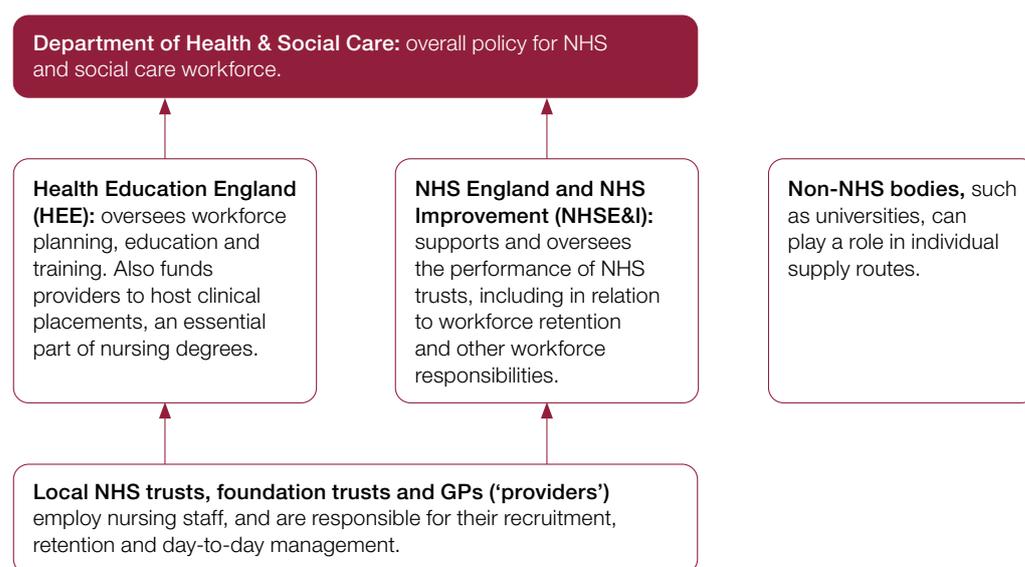
1 Nurses are critical to the delivery of health and social care services, working across hospitals, community services, care homes and primary care. In 2019, around 519,000 people in England were registered to practise as a nurse, while the NHS employed 320,000 nurses in hospital and community services, making up about a quarter of all NHS staff.

2 In January 2019, the NHS Long Term Plan acknowledged the need to increase staff numbers, noting that the biggest shortfalls were in nursing. The NHS set up the People Plan programme to decide how it would secure the workforce it needed to meet its future service commitments. In this report, we define workforce planning as the analysis and plans required to ensure that the NHS has the number and type of staff it needs, now and in the future.

3 A range of national and local NHS bodies are responsible for (nursing) workforce planning as well as supply, which includes training, recruitment and retention of staff. **Figure 1** sets out a basic overview, with fuller details in Figure 8 on page 20.

Figure 1

Responsibilities for nursing workforce planning and supply in England



► Accountability

Note

1 **Figure 8** provides a fuller description of roles and responsibilities.

Source: National Audit Office summary of responsibilities

4 While this report focuses on NHS nurses, nearly one in ten nurses works in adult social care, for which the Department of Health & Social Care (the Department) also has policy responsibility. The social care sector relies on similar entry routes for nurses as the NHS, but is made up of many providers who individually recruit and employ staff. The NHS People Plan primarily focuses on the health sector but envisages that local partnerships will cover health and social care workforce planning (see paragraph 14).

5 We have published a number of reports on workforce planning and supply, including coverage of the NHS, adult social care, the military and teachers. Departments have different approaches and systems for securing the workforce needed to deliver services. However, our studies found common challenges in identifying the true workforce need; recruiting and retaining staff; underperformance of workforce initiatives to address these; and managing the impact of shortages on existing staff. **Figure 2** sets out the general challenges we have observed that any future NHS People Plan must take care to address, and how these link to the current situation for NHS nurses.

6 The NHS People Plan has, for a variety of reasons, been delayed (see Summary, paragraph 11). Rather than delay for an uncertain time our own reporting, this report sets out the facts on:

- the scale of the NHS nursing workforce challenge;
- the challenges to the main entry routes to NHS nursing and more general workforce-related challenges that any future plans will need to address; and
- the progress made on the People Plan.

Figure 2

Observed challenges to workforce planning and supply from National Audit Office reports

	Commonly observed challenges in workforce planning and supply	Relevant sections of this report
Accountability	Ensuring responsibilities and accountabilities for workforce planning and supply are clear and well understood, and aligned with organisational influence, priorities and incentives.	Roles of national and local bodies and new workforce model (summary paragraph 13). Funding arrangements (summary paragraph 12). Interim People Plan (summary paragraph 10).
	Having effective national, regional or central coordination and oversight in workforce planning and supply.	Roles of national and local bodies (summary paragraph 13).
Workforce planning	Demonstrating a robust understanding of the future need for staff based on evidence and reliable forecasting, including key policy changes.	NHS Long Term Plan planning (summary paragraph 4). National modelling (paragraph 3.11). Local plans (summary paragraph 11).
	Understanding the performance of current and future supply routes for staff and how these address overall staffing requirements and any identified shortfalls.	National modelling (paragraph 3.11). See also individual supply routes (summary paragraphs 5–9).
	Setting out an overall workforce plan that meets government's objectives, and is actively managed and reviewed.	People Plan process (summary paragraphs 10–13)
	Having reliable information/data on workforce.	National modelling (paragraph 3.11). Local plans (summary paragraph 11).
	Integrating workforce, finance and performance strategies and planning.	NHS Long Term Plan planning (summary paragraph 4). People Plan process (summary paragraphs 10–13).
	Ensuring coverage of all types of staff in planning.	National modelling (paragraph 3.11). See also introductory paragraph 4.
Workforce supply	Ensuring training places reflect future staffing needs, as well as factors such as attrition and subsequent participation in the workforce.	Higher education market (summary paragraphs 5 and 6). Apprenticeship routes (summary paragraph 8).
	Ensuring funding arrangements for training and recruitment provide the right incentives for individuals, education providers and employers to achieve overall workforce objectives.	
	Addressing differences in staffing challenges by area and role in workforce planning and supply.	Scale and nature of nursing workforce challenge (summary paragraphs 2–3).
	Providing adequate support and funding for local bodies to implement workforce strategies.	Higher education market (summary paragraphs 5 and 6). Apprenticeship routes (summary paragraph 8).
	Ensuring workforce objectives are supported by wider cross-governmental policies and initiatives .	International recruitment (summary paragraph 7). Retention improvement (summary paragraph 9).
Addressing short-term shortfalls	Identifying a cost-effective, sustainable approach for filling shortfalls in staff, and supporting employers to fill shortfalls.	Not in scope of current report, but see paragraph 1.8.
	Appropriately managing the risk of an undesirable level of competition between employers for the same staff.	Not in scope of current report, but see paragraph 1.6.

Source: National Audit Office analysis of published reports

Summary

Key findings

The NHS nursing workforce

1 The NHS publicly acknowledged problems with current nursing shortages in 2017. In December 2017, Health Education England (HEE) published a draft workforce strategy on behalf of the NHS that noted pressures on the nursing workforce. By the time of the NHS Long Term Plan in January 2019, indicators such as the nursing vacancy rate had worsened. There is a significant time lag (at least three to four years) before policies to train more new nurses can have impact, meaning greater reliance in the short term on strategies such as overseas recruitment and improving retention (paragraphs 3.2 and 3.12).

2 Despite overall increases in the number of nurses, the NHS does not have the nurses it needs. Between 2010 and 2019, the overall number of NHS nurses in hospital and community services increased by 5%, although there were substantial reductions for some types of nurse - for example, a 38% reduction for learning disability nurses. Analysis by the Health Foundation for the shorter period 2010-11 to 2016-17 shows that the growth in nurse numbers (1%) was lower than increases in the amount of activity in hospital and community health services (23%). As at September 2019, the NHS had a nursing vacancy rate of 12%, a rise of 1% from September 2017. The Long Term Plan sets a target of reducing nursing vacancy rates to 5% by 2028. NHS England and NHS Improvement (NHSE&I) has estimated that around 80% of vacancies are filled by temporary staff (paragraphs 1.2 to 1.5).

3 The nature of the nursing workforce challenge varies by trust and region. Nursing vacancy rates are particularly high for mental health trusts (16%) and in London (15%). Levels of international recruitment vary considerably by trust and region. The proportion of overseas nurses varies from 30% to 36% in London regions to 5% to 8% in the north-east, north-west, and Yorkshire and Humber regions. Some sectors, such as primary care and community providers, also have a higher proportion of older nurses, who are closer to retirement (paragraphs 1.4, 1.6 and 2.21).

4 In January 2019, the NHS Long Term Plan set out service commitments for NHS England's £33.9 billion additional funding settlement that did not include detailed plans to secure the workforce needed to deliver them. The Long Term Plan contained service commitments – for example, on cancer care – and workforce commitments, including on nursing student numbers and retention, recognising that nursing workforce growth had not kept up with demand. It did not include detailed plans for how it would secure the nursing workforce required to deliver the commitments: it stated that a workforce plan would be published in 2019, as HEE budgets for workforce education and training beyond March 2020 were not yet agreed. Based on a review of two service areas, we found that, at the time of drawing up the Long Term Plan, there were quantified estimates of the nursing staff required for mental health service commitments. For cancer service commitments, there were no separate estimates of the overall cancer nursing capacity required, but an assumption that cancer needs would be met from the overall increase anticipated for the nursing workforce (paragraphs 3.1, 3.4 and 3.5).

Challenges in the main entry routes to NHS nursing

5 From 2017, the government changed the funding arrangements for nursing degree students, a major source of new NHS nurses. HEE has not been responsible for commissioning undergraduate nursing places since 2017, and the higher education market now determines the numbers of students, in response to demand from prospective students. A different approach is used in medical education, where HEE has a commissioning role and places are regulated and subject to targets. The changes in funding arrangements also removed NHS bursaries for nursing students, moving them on to the existing student loan arrangements. The Department of Health & Social Care (the Department) hoped to increase the number of places on nursing, midwifery and other health professional degree courses by up to 10,000 through these changes. In December 2019, the government announced the introduction of new maintenance grants for nursing students from September 2020 (paragraphs 2.5, 2.6, 2.10 and 2.16).

6 The number of applications for nursing degrees dropped significantly following the funding changes and subsequent numbers of new students have been below the Department's targets. In 2017, the first year of the new arrangements, the number of applicants fell by 11,000 (21%). Universities accepted a higher proportion of applicants than previously, so there was only a 3% fall in the number of new nursing students. Since 2017, numbers of nursing places have not increased as anticipated, and did not meet the Department's 2018-19 and 2019-20 commitments to a 25% increase. Trends in numbers of new students also differ markedly by nursing degree specialism (for example, mental health), region where applicants lived and for mature versus younger students. Early indications are that the number of applicants for September 2020 has risen by 6% compared with 2019, but is still lower than the number of applicants in 2017 (paragraphs 2.6 to 2.9 and 2.16).

7 The NHS Long Term Plan signals the need for a step change in the recruitment of overseas nurses, but recent national initiatives to increase numbers have not met their targets. Overseas recruits are already a major source of new nurses, making up around 20% to 25% of nurses joining the NHS. The number of overseas nurses working for the NHS rose by 28% between September 2014 and March 2019, with the proportion that they make up of the workforce remaining fairly steady since 2009 (17% as at March 2019). Since 2018, the Nursing and Midwifery Council has made a number of changes intended to improve and streamline the process for overseas nurses to register to practise in the UK. However, against a target of 2,500, the HEE-led global learner programme only attracted around 1,600 nurses in the two years 2018 and 2019. It now has an increased target of 15,000 nurses between 2020 and 2024 (paragraphs 2.20, 2.22 to 2.23 and 3.3).

8 Trusts and universities told us that there are financial and bureaucratic disincentives to increasing numbers through apprenticeship routes. Employers, supported by HEE, have developed a nursing degree apprenticeship route into nursing. They have also developed a new nursing associate role, which bridges the gap between registered nurses and healthcare assistants and aims to provide a new pipeline for registered nurses. Numbers of nursing degree apprentices were as expected (1,041 in 2018-19, up from 304 the previous year). For nursing associates, HEE projects that it will recruit 7,529 trainees between 1 January 2019 and 31 March 2020, against a target of 7,500 for this period. By December 2019, it had recruited 2,739 with regional trajectories in place for the remaining quarter. All the local trusts we visited were planning to make more use of apprenticeships, primarily nursing associates. Larger employers (including NHS providers) must pay an apprenticeship levy, which they can use to pay for apprenticeship training and assessment. In 2018-19, NHS organisations spent less than 30% of their levy payments. We heard about disincentives to the expansion of apprenticeships - in particular, that NHS trusts cannot use the apprenticeship levy to cover 'back-fill' costs. These refer to the costs of employing additional staff while an apprentice is doing clinical training, because during training apprentices cannot count towards the staffing complement. Universities also told us it was difficult to make apprenticeship courses sustainable, given factors such as the levels of scrutiny, bureaucracy and funding, and numbers of students (paragraphs 2.24 to 2.28).

9 Since 2017, NHSE&I has supported trusts with an intensive retention support programme. Between 2012-13 and 2018-19, although the number of nurses joining the NHS increased, so did the numbers leaving. NHSE&I's retention support programme, which started in 2017, has seen reductions in leaver rates for the first groups of trusts receiving support from the programme. The retention support programme works with trusts to help them address some of the key issues identified by available data on reasons for leaving, including: career progression; health and well-being; and support for new starters (paragraphs 2.30, 2.32, 2.34 and 2.35).

The NHS People Plan

10 NHSE&I and HEE have brought together bodies from across the sector to produce a full People Plan for the period up to 2025. The new Chief People Officer for NHSE&I chairs the National People Board, which oversees delivery of the People Plan and led collective efforts to bring together the Department, its arm's-length bodies, and representatives from across the sector. Eight working groups support the board, one of which has a specific focus on increasing nurse numbers (paragraph 3.6).

11 NHSE&I and HEE did not publish the People Plan as expected in 2019; it is now expected in spring 2020. The Long Term Plan stated that a workforce plan would be published in 2019. An Interim People Plan, published in June 2019, included an aim for a fully costed five-year plan later that year. The full People Plan was delayed and is now expected to publish in spring 2020, at least 12 months into the five-year funding settlement. External factors such as the postponement of the full spending review, and the December 2019 general election, have contributed to the delay. Local five-year strategy plans, including actions to increase nursing numbers, were due to be published in November 2019 but as at March 2020 have not been agreed or published. In December 2019, the government made a new pledge to increase the number of NHS nurses by 50,000 by 2025 (paragraphs 3.3, 3.4, 3.9 and 3.15).

12 While NHS England's budget is agreed up until 2024, this is not the case for HEE's budget, which covers workforce education and training. The £33.9 billion cash-terms increase for the NHS only applied to NHS England's budget, which covers the costs of employing staff to deliver the Long Term Plan commitments. It excluded HEE's budget – in particular, for workforce education and training - which the Long Term Plan anticipated would be agreed in a multi-year spending review later in 2019. The September 2019 spending round allocated a further £150 million to HEE for continuing professional development for nurses (and other groups) in 2020-21. Up to 2020-21, HEE also has access to funding for an additional 5,000 clinical placements (the practical training that nursing students must do as part of their degree). The spending round also allocated £60 million to People Plan activities for 2020-21 (paragraphs 3.1, 3.5 and 3.10).

13 The People Plan will detail new workforce-related roles for national, regional and local bodies, as well as responsibilities for delivery of the overall plan. The National People Board and supporting structures will be reviewed once the full People Plan is published. As part of the plan, NHSE&I and HEE are intending to set out each organisation's responsibilities for future delivery of the plan and to produce a new workforce operating model covering national, regional and local roles. The new model also includes a greater role in workforce for local partnerships of NHS bodies and local authorities, which is intended to cover both NHS and adult social care. Our previous work has noted that such partnerships are not statutory and are reliant on the goodwill of constituent bodies (paragraphs 1.12 to 1.14 and 3.10).

Part One

The nursing workforce challenge

Background to the nursing workforce

1.1 Nurses are critical to the delivery of health and social care services. To practise as a nurse, people must be registered with, and qualified to a standard set by, the Nursing and Midwifery Council. As at September 2019, 519,000 people living in England were registered to practise as a nurse. The NHS employed 320,000 nurses in England in hospital and community services as at September 2019, making up its single largest group of clinical staff and about a quarter of all staff.¹ In addition, 24,000 nurses were employed in GP practices.² Within NHS hospital and community services, nurses work across a wide variety of care settings, with the majority in acute, elderly or general care (**Figure 3**). Around two thirds (64%) have full-time contracts.³

Nursing shortages

1.2 Between September 2010 and September 2019, the overall number of NHS nurses in hospital and community services rose by 5%, from 272,000 to 286,000, but this masks very different patterns for different groups of nurses (**Figure 4** on page 14).⁴ The number of children's nurses increased by 55% in this period, while adult nurse numbers increased by 10%. By contrast, numbers of learning disability nurses fell substantially (by 38%), with smaller reductions for community and mental health nurses. In primary care, the number of nurses rose by 9% between September 2015 (when data first became available) and September 2019. As set out in more detail in paragraphs 2.31 and 2.33, the nursing workforce as a whole is getting older, which means a higher proportion of nurses approaching pensionable age.

1 Unless otherwise stated, analysis in this report excludes health visitors, whose services are commissioned by local authorities. In March 2019, the NHS employed about 9,000 health visitors.

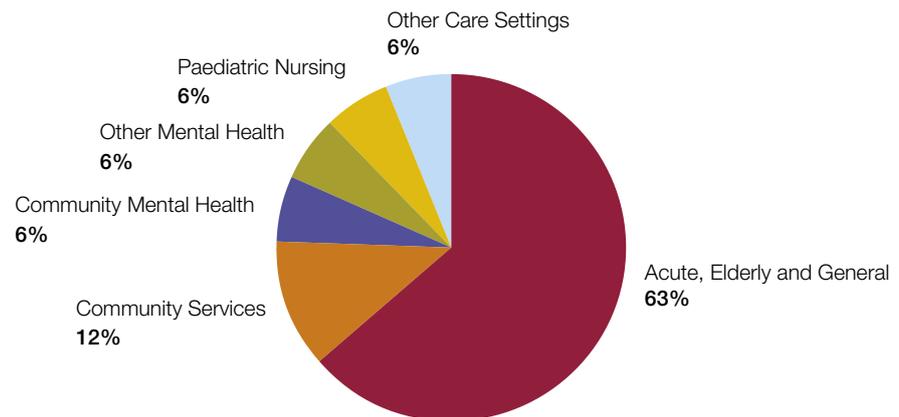
2 Other nurses not employed by the NHS may also provide NHS services, such as agency and bank nurses, who provide temporary staffing cover, and those working for independent providers commissioned to deliver NHS services. However, national data on these groups are unreliable or incomplete.

3 Figures in this paragraph are based on headcount data. Analysis of contracts includes health visitors.

4 Figures in paragraphs 1.2 and 1.3 are based on full-time equivalent (rather than headcount) data, which take account of contracted hours as well as numbers of nurses.

Figure 3

Care settings for NHS nurses, hospital and community services in England, March 2019

NHS nurses work across a wide variety of care settings**Notes**

- 1 Based on the number of nurses working in each care setting, which exceeds the overall headcount by around 600 due to some nurses working in more than one care setting. Percentages based on the overall headcount were the same as those based on the number of nurses working within each care setting, when rounded. Percentages may not sum to 100% because of rounding. Excludes health visitors.
- 2 Other care settings include neonatal nursing and learning disability settings.

Source: National Audit Office analysis of NHS Digital data

1.3 Although nurse numbers have increased over the past decade, so has demand: our 2016 report on managing the supply of NHS clinical staff highlighted the rising demand for nurses following the review into failures in care at Mid Staffordshire.⁵ The growth in NHS nurse numbers between September 2010 and September 2019 was also lower than for other clinical staff – for example, a 20% increase in doctors (excluding GPs). Analysis by the Health Foundation shows that, between 2010-11 and 2016-17, the growth in nurse numbers (1%) has been lower than in Office for National Statistics measures of activity in hospital and community health settings (23%), which could imply increased productivity but also increased workloads and pressure on staff.⁶

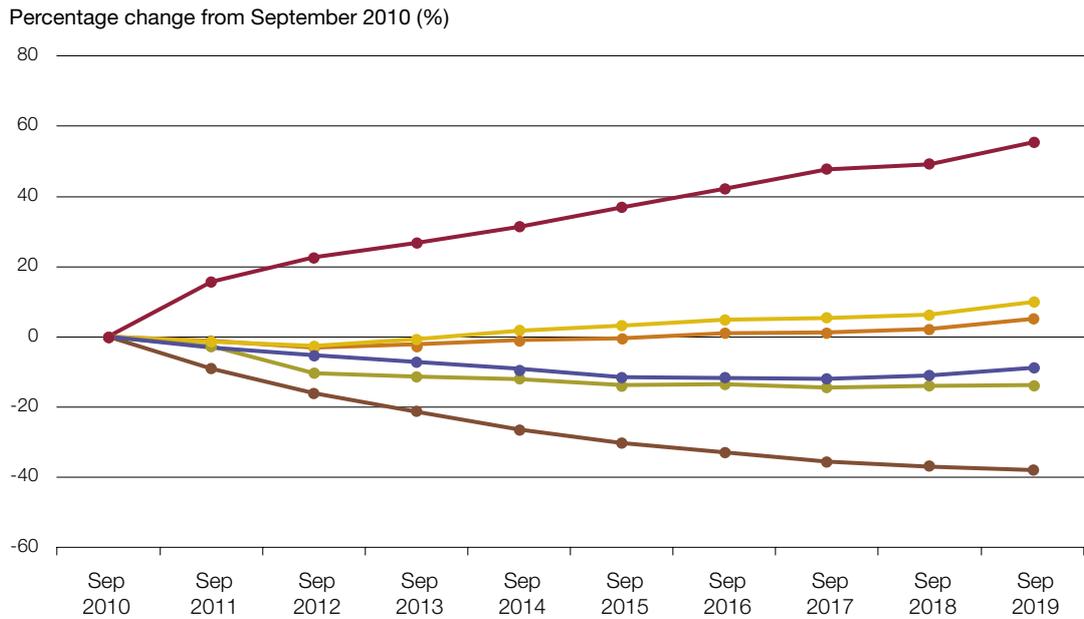
⁵ Comptroller and Auditor General, *Managing the supply of NHS clinical staff in England*, Session 2015-16, HC 736, National Audit Office, February 2016.

⁶ Health Foundation, *Health service output has increased faster than nurse numbers this decade*, April 2019, available at: www.health.org.uk/news-and-comment/charts-and-infographics/health-service-output-has-increased-faster-than-nurse-number. The Office for National Statistics publishes measures of “output growth” in hospital and community health services, which is the growth in activity (inpatient, outpatient and day-case procedures as well as other hospital activity), adjusted to account for the fact that some types of activity are more expensive than others, and for quality. The Health Foundation states that it therefore “gives an indication of the amount being ‘done’ in hospitals and community health settings”.

Figure 4

Percentage change in the number of nurses in NHS hospital and community services in England, 2010–2019

The overall increase in NHS nurses masks very different patterns for individual groups



	September 2010 (000)	September 2014 (000)	September 2019 (000)	Change 2010-19 (000)	Percentage change 2010-2019 (%)
All	272	270	286	14	5
Of which					
Childrens	15	20	23	8	55
Adults	169	173	186	17	10
Mental health	40	37	37	-4	-9
Community	41	36	36	-6	-14
Learning disabilities	5	4	3	-2	-38

Notes

- 1 Full-time equivalent data. Excludes health visitors.
- 2 Excludes data for primary care as the data are not yet reliable and are only available from September 2015.
- 3 Based on NHS Digital staff groups.

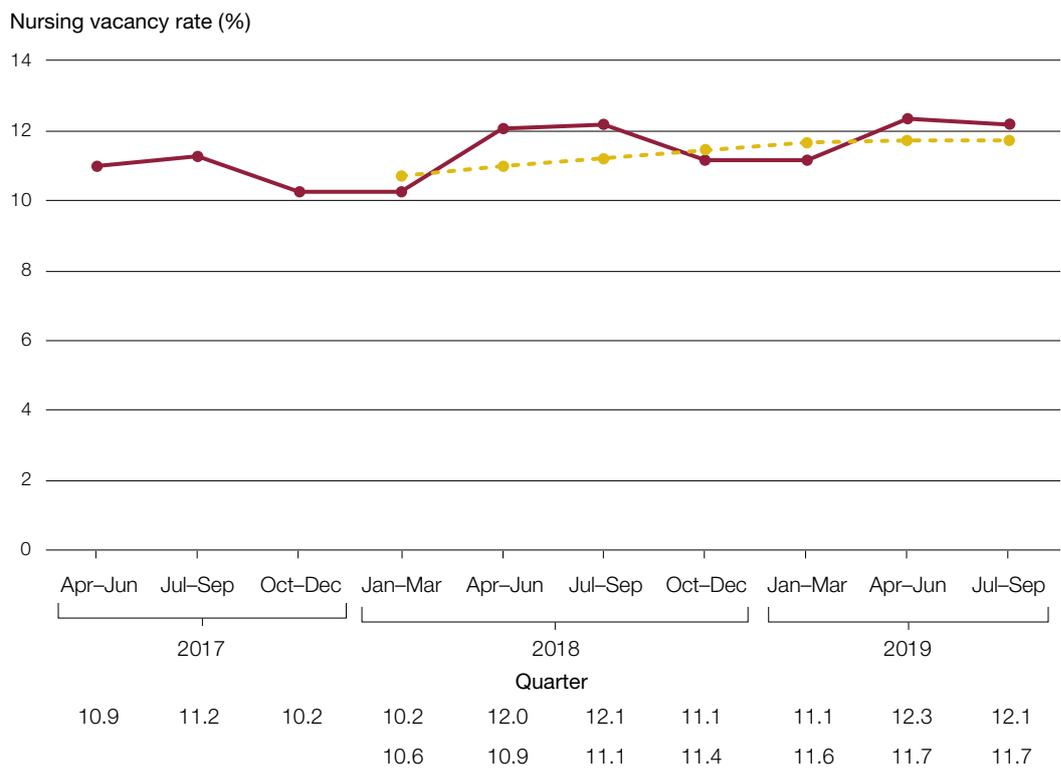
Source: National Audit Office analysis of NHS Digital data

1.4 In January 2019, the NHS Long Term Plan acknowledged the need to increase staff numbers, noting that the biggest shortfalls were in nursing.⁷ It set a target of reducing nursing vacancy rates to 5% by 2028. For the period July–September 2019, vacancy rates as reported by NHS trusts were 12% for nursing, equivalent to 43,590 full-time vacancies and higher than the overall staff vacancy rate of 9%.⁸ There were particularly high nursing vacancy rates for mental health trusts (16%) and London (15%): vacancy rates in London mental health trusts reached 20%. Vacancy numbers and rates follow a seasonal pattern: they have generally risen over the past two years, by 1% between July–September 2017 and 2019 (**Figure 5**).

Figure 5

Trends in NHS nurse vacancy rates in England, 2017–2019

Vacancy rates have generally risen between 2017 and 2019



Note

1 Full-time equivalent data.

Source: National Audit Office analysis of NHS England and NHS Improvement data

⁷ NHS, *The NHS Long Term Plan*, January 2019.

⁸ In addition to trust returns, NHS Digital also publishes experimental figures on numbers of advertisements, which is only a proxy as one advert can cover a number of vacancies.

1.5 It is not straightforward to monitor nursing shortages centrally. NHS providers must follow safer staffing guidance, although there are no prescribed staffing levels in England.⁹ The main published measure is care hours per patient day, which is focused on particular hospital settings and indicates average staff levels across a month. There are also practical difficulties in interpreting vacancy rates. NHS England and NHS Improvement (NHSE&I) has estimated that around 80% of vacancies are filled by temporary staff, which can also be covered by overtime. Increases in vacancy rates can also reflect expansion of a service area.

1.6 Workforce characteristics also vary by factors such as type of trust or region, which affect the staff recruitment and retention issues that may arise (**Figure 6**).¹⁰ Levels of international recruitment vary considerably: for example, 20% of nurses in acute trusts come from outside the UK compared with 7% in both community and mental health trusts. Paragraph 2.21 on page 33 also highlights regional variations in international recruitment. Overall, nursing remains a predominantly female profession (88%), but mental health trusts have a much higher percentage of male nurses (20% compared with 12% in all trusts). A higher proportion of primary care and community nurses are older (35% and 23% respectively, aged 55 and over). Primary care nurses are also distinctive in terms of the higher proportion of part-time working (84%). In our local visits, we found that the nature of local competition for nursing staff varied from place to place, and could include private healthcare providers, other NHS trusts and primary care, as well as social care and local employers (not in healthcare).

1.7 Concerns about the impact of nursing shortages have persisted since Mid Staffordshire,¹¹ with a 2019 review by the University of Southampton finding that registered nurse staffing levels had not risen to meet demand.¹² In its 2018-19 State of Care report, the Care Quality Commission raised general concerns about the impact of low staffing levels affecting the quality of patient care, as well as increasing pressure on staff and further contributing to staff shortages.¹³ Other studies have shown an association between registered nurse staffing and increased mortality during hospital admission,¹⁴ and patient care more generally.¹⁵

9 In Scotland and Wales, legislation is used to regulate NHS staffing. For example, in Scotland, health boards and service providers have a statutory duty to follow appropriate methodology and ensure appropriate numbers of suitably qualified staff providing care.

10 Figures in this paragraph are based on headcount data. Analysis of contracts includes health visitors.

11 Robert Francis QC, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, February 2016.

12 Ball J, Barker H, Burton C, Crouch R, Griffith P, Jones J, Lawless J, Rycroft Malone J., *Implementation, impact and costs of policies for safe staffing in acute trusts*, University of Southampton, 2019.

13 Care Quality Commission, *The state of health care and adult social care in England*, HC 9, October 2019.

14 Griffiths P, Maruotti A, Recio Saucedo A, Redfern O, Ball J E, Briggs J, Dall'Ora C, Schmidt P, Smith G and Missed Care Study Group, *Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study*, *BMJ Qual Saf*, 28(8), 609-617. doi:10.1136/bmjqs-2018-008043, August 2019.

15 Redfern O, Griffiths P, Maruotti A, Recio Saucedo A, Smith G and Missed Care Study Group, *The association between nurse staffing levels and the timeliness of vital signs monitoring: a retrospective observational study in the UK*, *BMJ open* 9(9), e032157. doi:10.1136/bmjopen-2019-032157, September 2019.

Figure 6

Demographic and job characteristics of NHS nurses, hospital and community services (September 2018) and primary care (March 2019) in England

Workforce characteristics vary by type of trust

	All hospital/ community services (%)	Acute trusts (%)	Of which Community providers (%)	Mental health trusts (%)	Primary care (%)
Age:					
Under 25	4	5	2	3	1
25-34	25	28	17	19	8
35-44	25	25	23	24	20
45-54	29	28	35	34	37
55+	16	15	23	19	35
Gender:					
Female	88	90	93	80	98
Male	12	10	7	20	2
Ethnicity:					
White	76	74	87	80	92
Black African/Caribbean/Black British	8	7	7	13	3
Asian/Asian British	10	12	4	4	4
Mixed/Other	6	7	3	3	2
Nationality:					
United Kingdom	83	80	94	92	*
European Economic Area	7	8	3	3	*
Rest of the world	10	12	4	5	*
Grades:					
Band 5 (and below)	47	51	41	34	*
Band 6	31	28	33	42	*
Band 7	17	16	20	18	*
Band 8 and above	6	5	7	6	*
Non Agenda for Change grade	1	1	0	0	*
Hours worked:					
Part time (<1 FTE)	36	+	+	+	84
Full time (1+ FTE)	64	+	+	+	16

Notes

- 1 Headcount data. Excludes health visitors, with exception of hours worked.
- 2 * = data not collected; + = data not accessed for this study. Percentages may not sum to 100% because of rounding.
- 3 Ethnicity and nationality exclude unknown or not stated. FTE stands for full-time equivalent. Agenda for Change is the national NHS pay and grading system which covers nurses: band 5 is the entry-level grade for nurses.
- 4 As of March 2019, except for primary care which is September 2018.

Source: National Audit Office analysis of NHS Digital data

1.8 Shortages of nursing staff also have an impact on value for money. Our 2020 report on NHS financial sustainability highlighted the continued risk that the NHS will be unable to use the extra funding from the long-term settlement optimally because of staffing shortages and having to use more expensive agency staff to deliver additional services.¹⁶ In 2018-19, trusts spent £2.4 billion on agency staff and £3.4 billion on bank staff, which will include nurses.¹⁷

Recent developments affecting the nursing workforce

1.9 In 2019, in addition to the publication of the NHS Long Term Plan, a number of developments affected the nursing workforce and workforce planning more generally. These included the publication of the Interim People Plan supporting the Long Term Plan, and the announcement of the introduction of new maintenance grants for nursing degrees. These are summarised in **Figure 7**, and discussed in more detail in Parts Two and Three.

NHS workforce roles and responsibilities

1.10 At the national level, a number of different bodies are responsible for oversight of the NHS nursing workforce:

- the Department for Health & Social Care (the Department) has overall policy responsibility for the NHS and social care workforces;
- Health Education England (HEE), an arm's-length body of the Department, oversees workforce planning, education and training;
- NHSE&I, also an arm's-length body, provides oversight and support to NHS trusts and foundation trusts (including on workforce-related activities and staff management), and leads on quality and diversity, professional leadership and the negotiation of primary care contracts;¹⁸
- providers (including NHS trusts, foundation trusts and GP practices) are responsible for recruiting and employing staff and their day-to-day management.

Figure 8 on page 20 details general roles in relation to the workforce, while Part Two contains more details about roles in workforce supply, which vary by entry route.

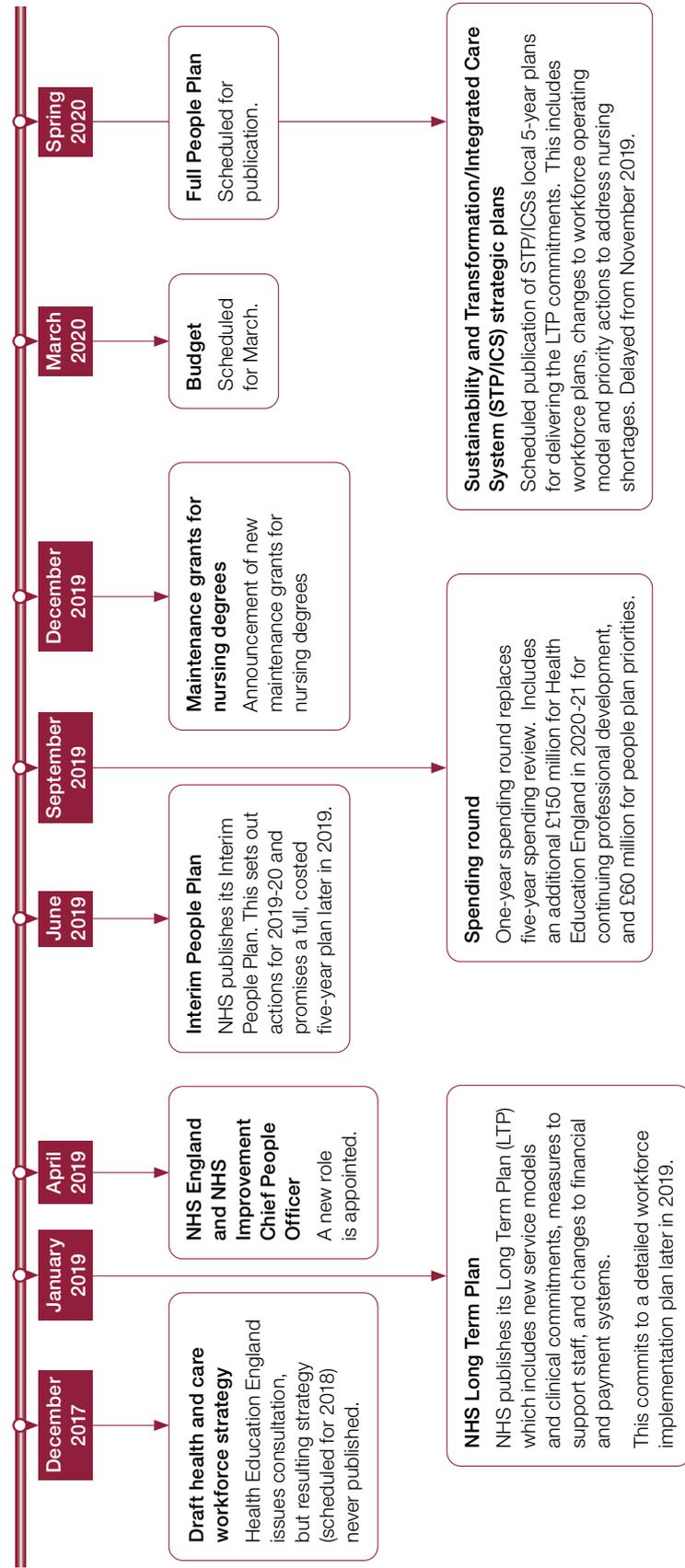
¹⁶ Comptroller and Auditor General, *NHS financial management and sustainability*, Session 2019-20, HC 44, National Audit Office, February 2020.

¹⁷ While agencies are private bodies, NHS staff banks are managed by or on behalf of a trust to supply staff. NHS Professionals, owned by the Department of Health & Social Care, is the largest NHS staff bank. NHS staff may work bank or agency hours in addition to their contracted hours.

¹⁸ Since 1 April 2019, the two previously separate organisations of NHS England and NHS Improvement have been more closely aligned under a single chief executive officer.

Figure 7
Timeline of recent developments in national workforce strategy and planning

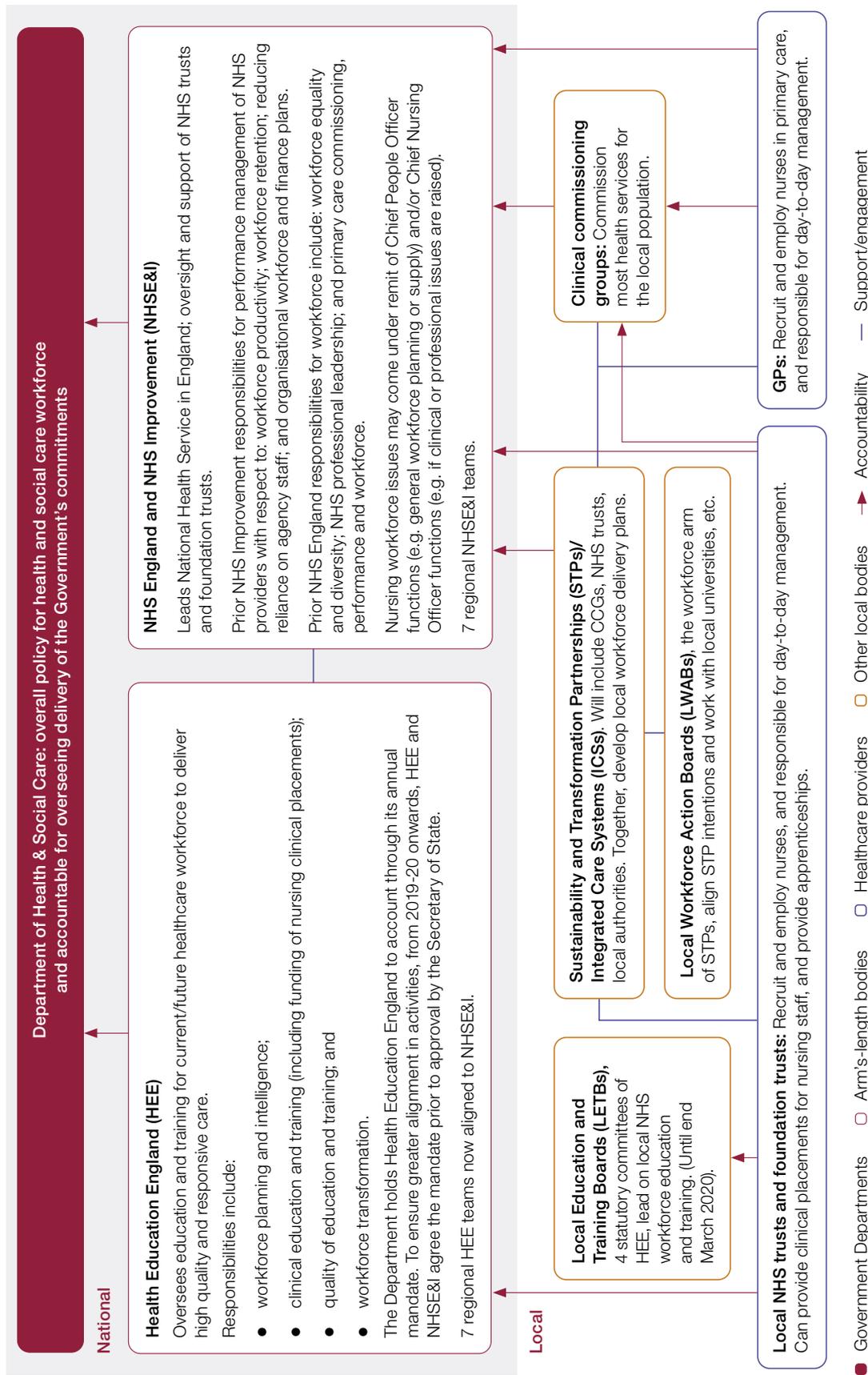
In 2019 there were a number of developments affecting the nursing workforce



Source: National Audit Office analysis of published plans and strategy documents

Figure 8
National roles and responsibilities in NHS nursing workforce in England

A number of different bodies are responsible for oversight of the NHS nursing workforce



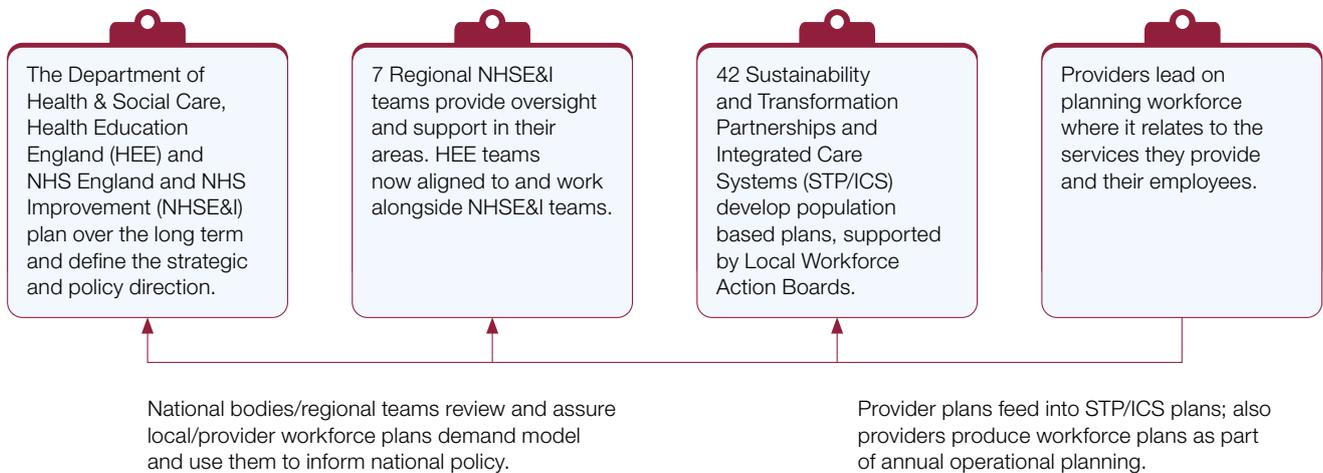
Source: National Audit Office analysis of Department of Health & Social Care, NHS England and NHS Improvement and Health Education England information

1.11 The Interim People Plan set out, at a high level, new national and local roles for workforce planning (**Figure 9**). In 2016, we reported that the creation of HEE in 2012 meant that there was a national body tasked with making strategic decisions about workforce planning.¹⁹ Since then, HEE has aligned more closely with NHSE&I: in October 2018, HEE announced it would restructure its local teams to match NHSE&I’s new regional structure and from 2019-20, it agreed its mandate with NHSE&I prior to approval by the Secretary of State. HEE-led initiatives appear to have been superseded by the Long Term Plan and supporting People Plans (see paragraph 3.6). These include the national workforce advisory board, which coordinated system-wide action on workforce challenges and a 2017 draft health and social care workforce strategy, which was never finalised. NHSE&I’s role in relation to workforce has expanded, including the appointment of a new chief people officer. The Long Term Plan noted that NHS Improvement now had lead responsibility for the NHS workforce. An internal HEE paper in November 2019 noted a number of areas of overlap with NHSE&I, including future workforce design, workforce planning and intelligence, data and analysis.

Figure 9

Workforce planning roles of national and local health bodies in England

The Interim People Plan sets out a more pivotal role for local partnerships in workforce planning



Source: National Audit Office analysis of Interim People Plan

19 Comptroller and Auditor General, *Managing the supply of NHS clinical staff in England*, Session 2015-16, HC 736, National Audit Office, February 2016.

1.12 The Interim People Plan also envisages a more pivotal role for integrated care systems, which are local partnerships of NHS bodies and local authorities working across an area.²⁰ These, in common with previous initiatives like sustainability and transformation partnerships and local workforce action boards, aim to bring together health and social care bodies for activities such as workforce planning and strategy. However, as we have set out in previous reports, they are not statutory and are reliant on the goodwill and resources of constituent bodies.²¹ In 2018, the Care Quality Commission reported, on the basis of 20 local system reviews, that it had not been assured of effective joint workforce planning across health and social care.²²

1.13 Partnerships vary in their readiness and capacity to take on this wider workforce planning role. Previous NAO work on financial sustainability found that sustainability and transformation partnerships started from different positions because, in some areas, partnership working already existed.²³ Our visits confirmed that partnerships were at different stages in terms of system workforce planning and setting up the right structures to support this. Two areas also raised issues with their capacity to access or make use of data on workforce. Recognising these issues, NHSE&I has provided a framework that areas can use to self-assess and improve their maturity in system workforce planning.

1.14 As part of the full People Plan, the NHSE&I and HEE are planning to produce a new workforce operating model, meaning that the system will be in transition. As noted in our 2020 report on NHS financial sustainability, NHSE&I itself is still in a period of transition as its two predecessor organisations come together.²⁴ Regional NHSE&I teams, an important source of support, are still setting up and recruiting staff. Of the seven regional teams, five had appointed directors of workforce and organisational development by April 2019, one was appointed in January 2020, and one had an acting director in place. All the partnerships we visited were generally positive about regional HEE teams, although two noted that the role of HEE more generally was changing.

20 As set out in the Long Term Plan, all areas are expected to become integrated care systems by April 2021.

21 Comptroller and Auditor General, *NHS financial sustainability*, Session 2017–2019, HC 1867, National Audit Office, January 2019; Comptroller and Auditor General, *NHS financial management and sustainability*, Session 2019–20, HC 44, National Audit Office, February 2020.

22 Care Quality Commission, *Beyond barriers: how old people move between health and social care in England*, CQC-411, July 2018.

23 Comptroller and Auditor General, *NHS financial sustainability*, Session 2017–2019, HC 1867, National Audit Office, January 2019.

24 Comptroller and Auditor General, *NHS financial management and sustainability*, Session 2019–20, HC 44, National Audit Office, February 2020.

Part Two

Challenges in the main entry routes to NHS nursing

2.1 This part looks at the recent performance of different entry routes into NHS nursing as well as nurse retention, and therefore where there may be challenges in the future in securing staff. We examine roles and responsibilities for managing supply for each route, recent performance, and current and future interventions.

2.2 We focus on the biggest pipelines currently or where the NHS anticipates the largest increases in numbers. This comprises undergraduate degree routes; overseas recruitment; apprenticeships and nursing associates. We also include initiatives to improve retention: keeping existing nurses for longer could mean higher numbers of nurses working in the NHS in the future, although these would not be new nurses. We do not cover in detail smaller pipelines such as return to practice.

Entry to nursing through undergraduate degrees

2.3 Recent graduates are a major source of new nurses to the NHS, although there is no definitive data set which directly links graduates with NHS employment. Each year, around 30,000 nurses join the NHS in England. In 2018, 17,000 (English-domiciled) nurses graduated with an undergraduate degree, and around 4,500 with a post-graduate degree.²⁵ Smaller numbers also graduate through apprenticeship routes. However, not all new graduates go on to work as nurses, and not all of those who become nurses will join the NHS.²⁶

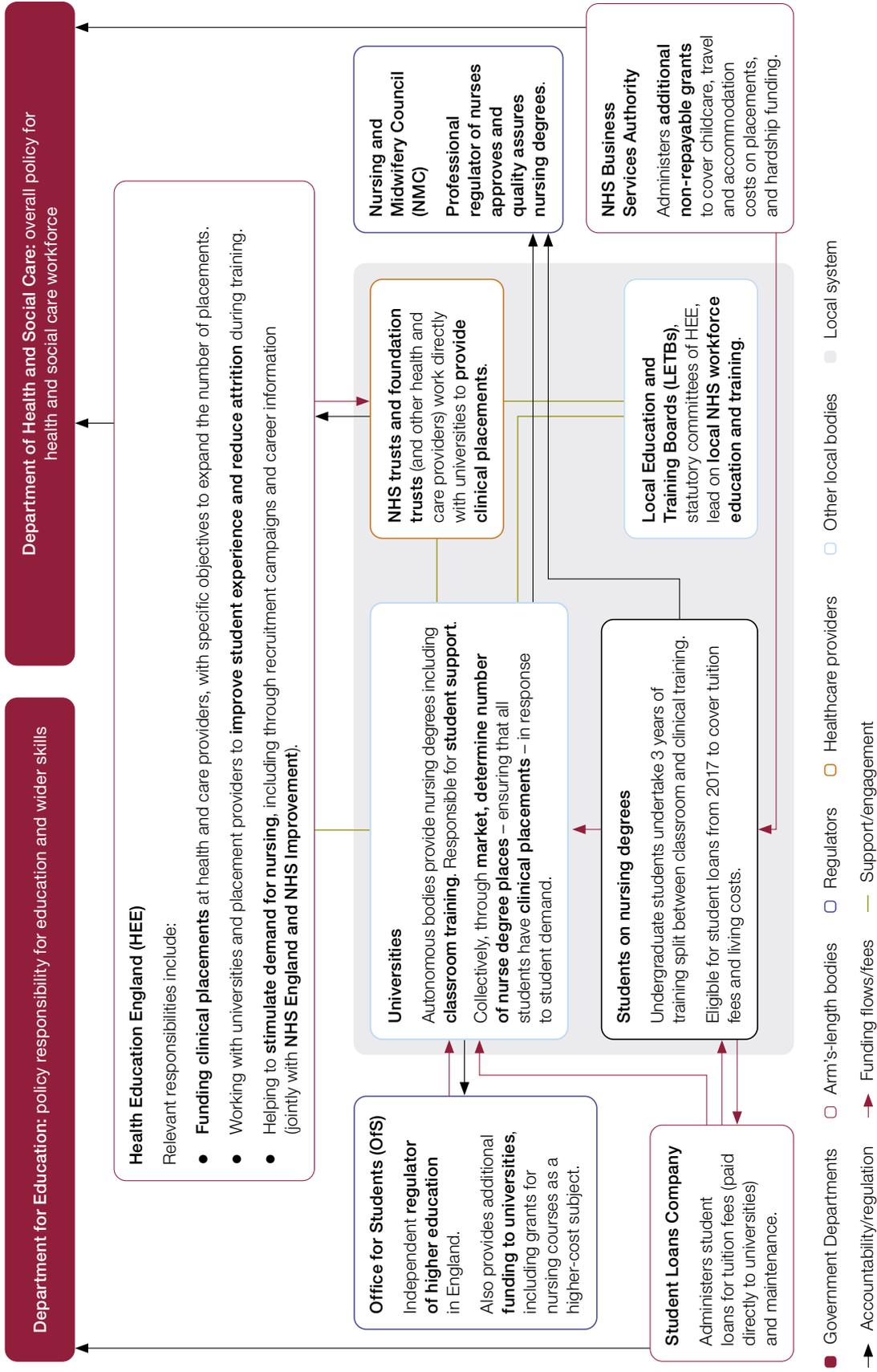
2.4 Nursing degrees are provided by higher education institutions (referred to as 'universities' from here on) and must be approved by the Nursing and Midwifery Council and university. **Figure 10** overleaf sets out the main planning, provision and funding responsibilities in relation to undergraduate nursing degrees. Undergraduate courses generally last for three years, with half the time spent in the classroom and half the time (at least 2,300 hours) on clinical placement. Student nurses on clinical placement work in a range of health and care settings under supervision to gain practical experience.

²⁵ Based on Higher Education Statistics Agency data for England-domiciled graduates from UK providers.

²⁶ All figures in Part Three are based on headcount data, unless stated otherwise.

Figure 10 Responsibilities for planning, provision and funding of undergraduate nursing degree courses in England

Numbers of nursing degree places are determined by the market in response to demand from prospective students



Source: National Audit Office analysis of published documentation from health and higher education bodies

2.5 Prior to autumn 2017, Health Education England (HEE) directly commissioned nursing undergraduate places, paying tuition fees to universities and bursaries to students to cover their living costs. As set out in the 2015 spending review, from autumn 2017, the government changed from this direct commissioning model to reliance on the market (universities) to provide places in response to demand from prospective students. It also removed bursaries for nursing, midwifery and allied health professional students. Instead, new student nurses moved on to the existing student finance arrangements, with most eligible to take out full loans for tuition fees and maintenance costs, creating a legal obligation to make repayments based on earnings. In the first year of the new arrangements, the maximum student maintenance loan available was £8,430.²⁷ In 2016-17, the main components of the NHS bursary were a £1,000 non-means tested grant plus a means-tested grant worth up to £3,191. Students eligible for an NHS bursary also qualified for a non-means tested maintenance loan of £2,324.²⁸

2.6 The Department of Health & Social Care (the Department) intended to increase the number of places on nursing, midwifery and other health professional degrees (such as occupational therapy or physiotherapy) by up to 10,000 through the change in funding arrangements.²⁹ Its rationale was that this removed the funding constraint on the number of places and left universities free to respond to demand from students. In 2017, the first year of the new arrangements, the number of applicants to undergraduate nursing degrees fell by 11,025 (21%) from 2016 (**Figure 11** overleaf).³⁰ However, universities accepted a larger proportion of applicants, which helped to maintain numbers of students: the number of acceptances dropped by 3% between 2016 and 2017. One university we visited detailed a number of steps it had taken to sustain its adult nursing course, including more promotion of the course, moving to a single intake per year, closer links with health bodies for placements, extending access to university bursaries and offering more routes to a full nursing degree (eg the introduction of a fast-track postgraduate route into nursing). Although offers are based on a combination of interview, qualifications and previous experience, there is some indication that students had lower A-level grades. Based on 18-year-olds with three A-levels accepted on to nursing courses between 2016 and 2018, our analysis suggests a decrease in grades equivalent to one A-level dropping by one grade.

27 This is the full year rate of maintenance loan for students with household incomes of £25,000 or less who are not eligible for benefits and who are living away from the parental home and studying outside London. Higher rates of loan were available for low-income students eligible for benefits and those living away from home and studying in London.

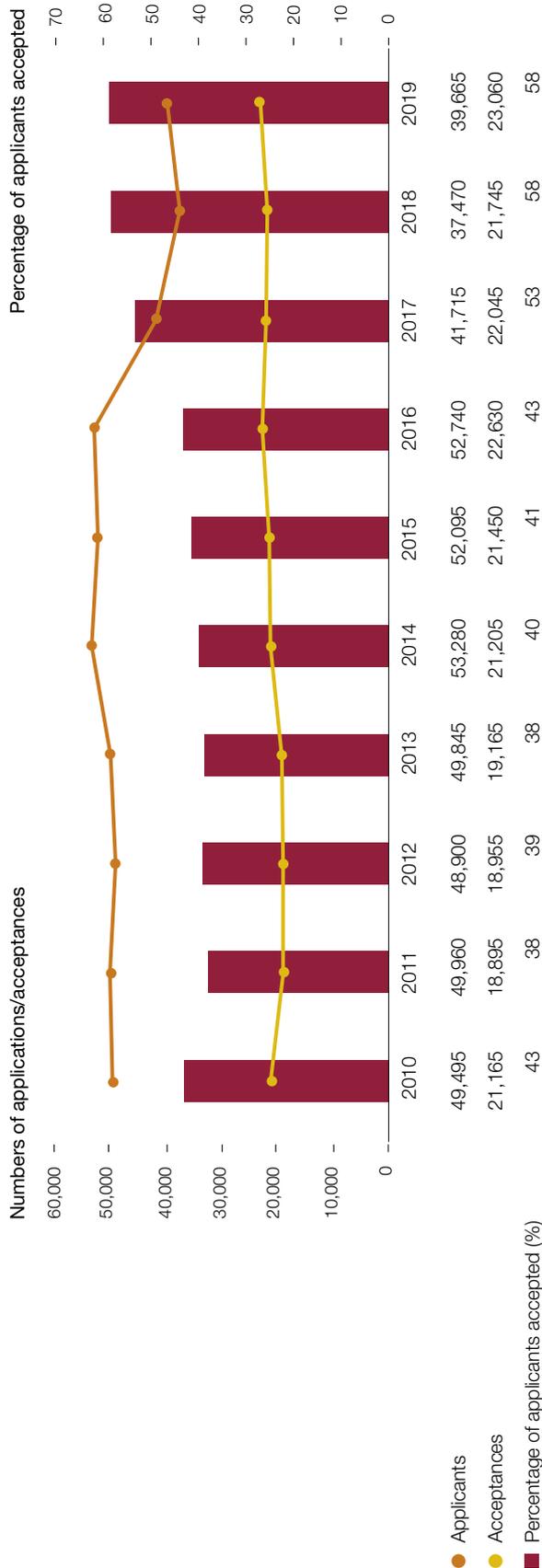
28 This is the full year rate of maintenance loan for students living away from home and studying outside London. A higher rate of loan applied to students living away from home and studying in London.

29 According to Higher Education Statistics Agency data, around three-quarters of students on nursing, midwifery or health professional degrees in 2017/18 were studying nursing.

30 Analysis of published UCAS data in paragraphs 2.6 and 2.8 and Figure 11 includes midwifery courses. Based on analysis of UK-domiciled students and English providers, around one in six applicants and one in ten acceptances were for midwifery courses.

Figure 11
Nursing degree applicants and acceptances, 2010–2019

Applications to nursing degree courses fell sharply in 2017



Notes

- 1 Based on England-domiciled applicants, UK providers.
- 2 Includes midwifery courses.

Source: National Audit Office analysis of Universities and Colleges Admissions Service data

2.7 The Long Term Plan committed to increase clinical placements by up to 25% in 2019-20, to support the Department's intended 25% increase in nursing undergraduate places, equivalent to an additional 5,000 places. This reiterated a similar commitment for 2018-19 (see paragraph 2.5). As part of the Interim People Plan, NHS England and NHS Improvement (NHSE&I) worked directly with trust directors of nursing in 2019 to increase capacity among existing placement providers, which identified potential additional capacity of around 7,700 placements.

2.8 Since 2017, numbers of nursing undergraduates have not increased as hoped, failing to meet the 2018-19 and 2019-20 commitments of a 25% increase (Figure 11). Compared with 2017, the number of students starting undergraduate degrees in 2018 fell by 1%, while in 2019 numbers were 5% higher.

2.9 There is substantial variation in the trends in student numbers for different groups (Figure 12 overleaf). Between 2016 and 2018, acceptances onto nursing degrees rose for children's and mental health nursing degrees, compared with a large fall for learning disability nursing (which also had a larger than average fall in applications). There were also larger falls for students aged 20-39, who historically have been more likely to apply for mental health nursing. Previous research has suggested that mature students are generally more affected by available funding and financial considerations. For applicants living in the north-east, north-west and Yorkshire and Humber, numbers of acceptances rose by 7% to 10% compared with falls of over 20% for those in the east of England and the south-east.

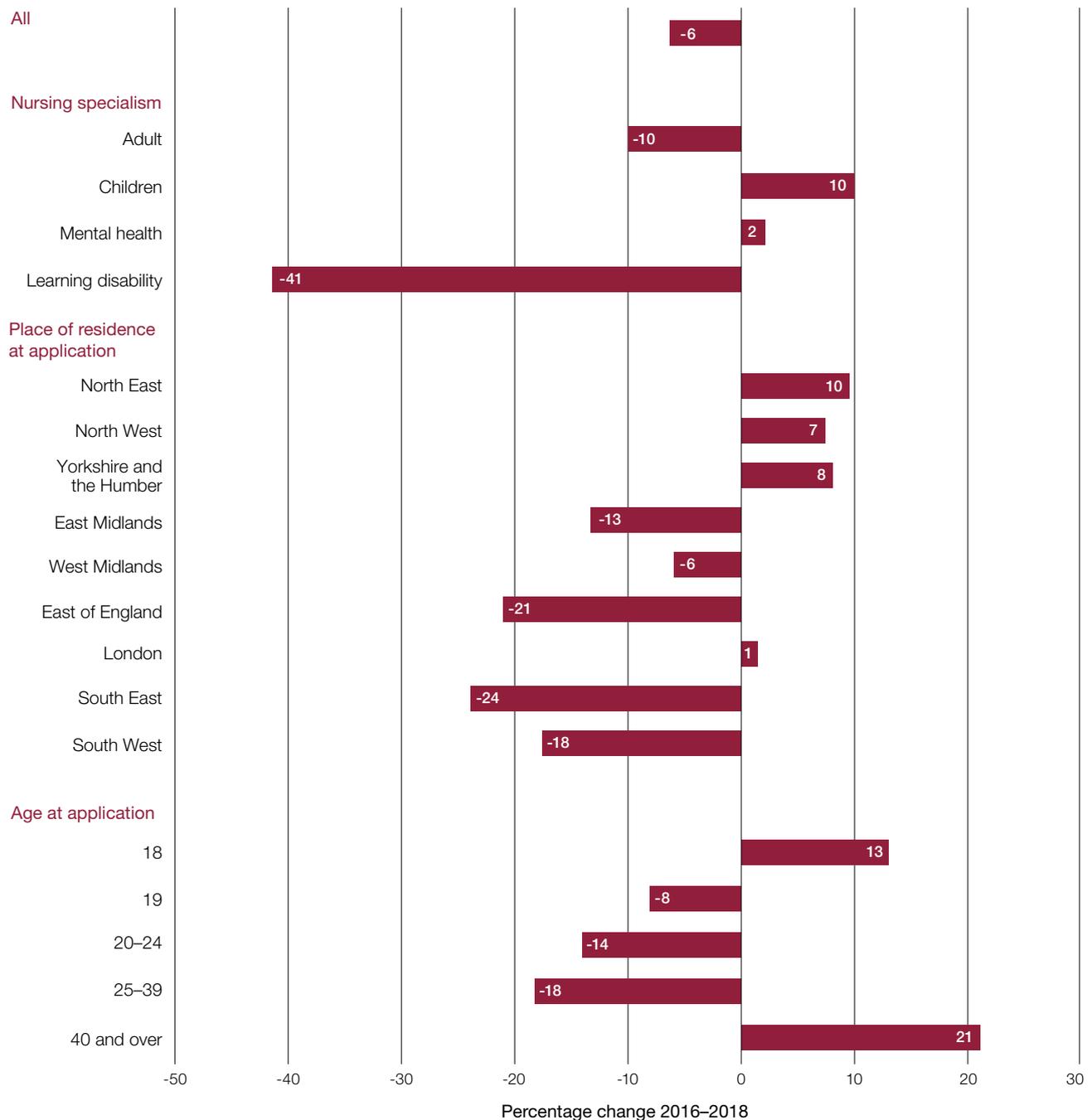
Higher education market

2.10 The Department and national health bodies told us that the policy decision to rely on the higher education market is not providing the number and type of nurses the NHS needs. The Office for Students told us that it may still be too early to judge the success of the market approach and that it is currently working with HEE and others to understand this and to identify any actions that may be needed. When a public service is delivered through a market mechanism, we would expect the responsible bodies to understand their levers to improve how the market delivers and, if the market cannot support the objective, consider alternative mechanisms. In September 2018, the Department established the Nursing Supply programme board to oversee delivery of, and provide assurance to the Department's ministers on, actions to increase nursing workforce supply. The reliance on the market contrasts with approaches in other areas, principally medical education, where HEE has a commissioning role, numbers of places are regulated, and the Office for Students allocates and operates targets for places.

Figure 12

Percentage change in acceptances to nursing degree courses by region, nursing specialism and age of applicant, 2016–2018

There is substantial variation in student numbers following the removal of the nursing bursary



Note

1 Based on UK-domiciled students, English universities.

Source: National Audit Office analysis of Universities and Colleges Admissions Service data, supplied to Department of Health & Social Care

2.11 One NHS influence over the higher education market is the provision of clinical placements. The policy intention has been to increase placements in order to support an increase in the number of university places. HEE is responsible for funding clinical placements and oversight of placement capacity, but has not met previous commitments to increase placements (see paragraph 2.8). However, placements are a limited lever for expansion because they are not the only barrier, given the large and sustained fall in applications after 2016 (Figure 11). A survey by the Council of Deans of Health found that a “significant proportion of universities” felt unsure of their ability to increase nursing student numbers even if there were additional placements available.

2.12 Placements are not managed centrally: each university negotiates these locally with health and care providers. Universities we visited described the logistical complexities of this process, which include identifying suitable locations for students to travel to and varied placements for each student; ensuring adequate supervision capacity; and coordination with other placements (other universities or placements for doctors and other professions). In interviews with higher education stakeholders, we heard that some previous announcements about increased placement capacity had come too late in the academic cycle for universities to respond.

2.13 At the time of reporting, HEE could not aggregate the regional data from its teams that funded clinical placements, so did not have central oversight of costs and what sectors or providers were hosting placements. HEE is planning to introduce more consistent reporting and validation from April 2020.

2.14 HEE leads on career promotion, with the Department, NHSE&I and HEE working jointly on a general recruitment campaign for nurses in 2018/19. They estimate that the online campaign resulted in 70,000 referrals to the NHS jobs website and contributed to the increase in applicants between 2018 and 2019.

2.15 HEE also leads on work to reduce attrition during training, supporting universities (and placement providers) who are primarily responsible for addressing this. Students can drop out for various reasons including: financial pressures, making the wrong career choice, clinical placement experience, academic ability, workload and lack of support, as well as personal reasons. Measuring attrition is not straightforward as there is debate about the best indicators to use, particularly in relation to students who may be delaying, rather than permanently stopping, their studies. The Office for Students’ general measure of attrition is the continuation rate – broadly, the proportion of students still studying a year after starting their course – which was 93% for nursing students starting courses in 2016, similar to levels for all subjects. However, HEE has estimated that 33% of students starting courses in 2013 and 2014 did not complete their studies on time, although attrition generally decreased between 2009-10 and 2016-17. In 2015, HEE started its RePAIR project, which included aims to identify and promote best practice in, and agree, a national approach to improving retention. In 2019-20, it set a target of increasing the proportion of students completing their studies on time to 85% by 2024.

2.16 In December 2019, the government announced the introduction of new maintenance grants for nursing students, effective from September 2020. This consists of a non-repayable grant of between £5,000 to £8,000 to help with living costs.³¹ Students will still pay their own tuition fees and the higher education market will therefore still determine the number of places. As at 15 January 2020, 32,490 people living in England had applied for nursing degrees starting in September 2020. This represented a 6% rise on the same time in the previous year (30,650), but was still 4% lower than the equivalent numbers in 2017 (33,810).³²

2.17 The NHS expects that local health systems and bodies will work with universities in their area, but in our visits we found a variation in approaches.³³ All four universities we spoke to worked closely with local healthcare providers to coordinate placements and on course-related issues such as recruitment or curriculum, with three saying relationships were very good. However, one university mentioned that they were not involved in wider system workforce planning or decisions that might affect them.

Overseas recruitment

2.18 NHS providers are responsible for overseas recruitment, singly or in partnership with other providers in their area. Both NHSE&I and HEE provide support for overseas recruitment strategy and planning through their regional teams, and HEE also runs international partnership and exchange programmes.

2.19 International recruitment to the NHS is influenced by other bodies and external factors outside the NHS's control (**Figure 13**). Overseas nurses must meet qualification, competency and language standards as set by the Nursing and Midwifery Council in order to register to practise. Nurses are also subject to immigration policies set by the Home Office. Currently, nurses are on the shortage occupation list and also do not have to meet the minimum salary requirements for Tier 2 visas (which, as at March 2020, was £30,000 per annum).³⁴ In December 2019, the government announced planned changes to immigration, including a move to a 'points-based' system and the introduction of a new visa for NHS healthcare staff. Research by the Department estimated costs of recruiting a nurse from overseas at around £12,000 on average.

31 Eligible students will receive an annual grant of at least £5,000, with additional funding of up to £3,000 in regions or specialisms that have difficulties with recruitment, and to help cover childcare costs. Students will still be eligible for student loans for both tuition fees and maintenance costs.

32 Based on England-domiciled applicants for UK universities and includes midwifery courses. These figures are based on UCAS data on applicants as at 15 January, and will differ from the applicant numbers in Paragraph 2.6 and Figure 11.

33 At the national level, the Department told us that it convened a group called the Higher Education National Strategic Exchange with membership from across the higher education sector, which is an informal discussion group with no recorded governance or actions.

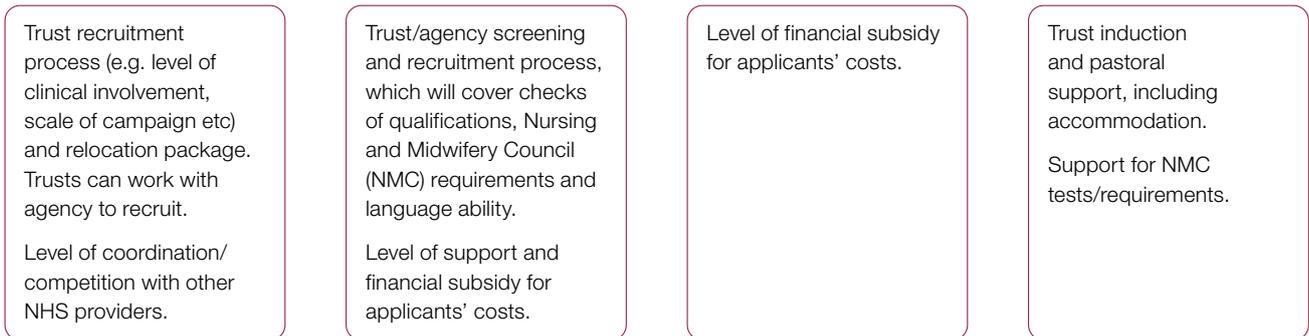
34 Tier 2 visas are one of the main immigration routes for working in the UK, which apply to skilled workers holding a job offer in the UK. The shortage occupation list is drawn up by the independent Migration Advisory Committee and allows fast-tracking of skilled migrants into the UK to meet a national shortage.

Figure 13

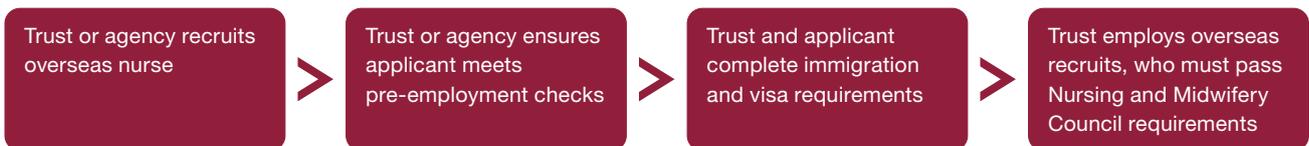
Key elements in recruitment of overseas nurses to the NHS, and factors affecting recruitment

International recruitment to the NHS is also influenced by other bodies and external factors outside the NHS's control

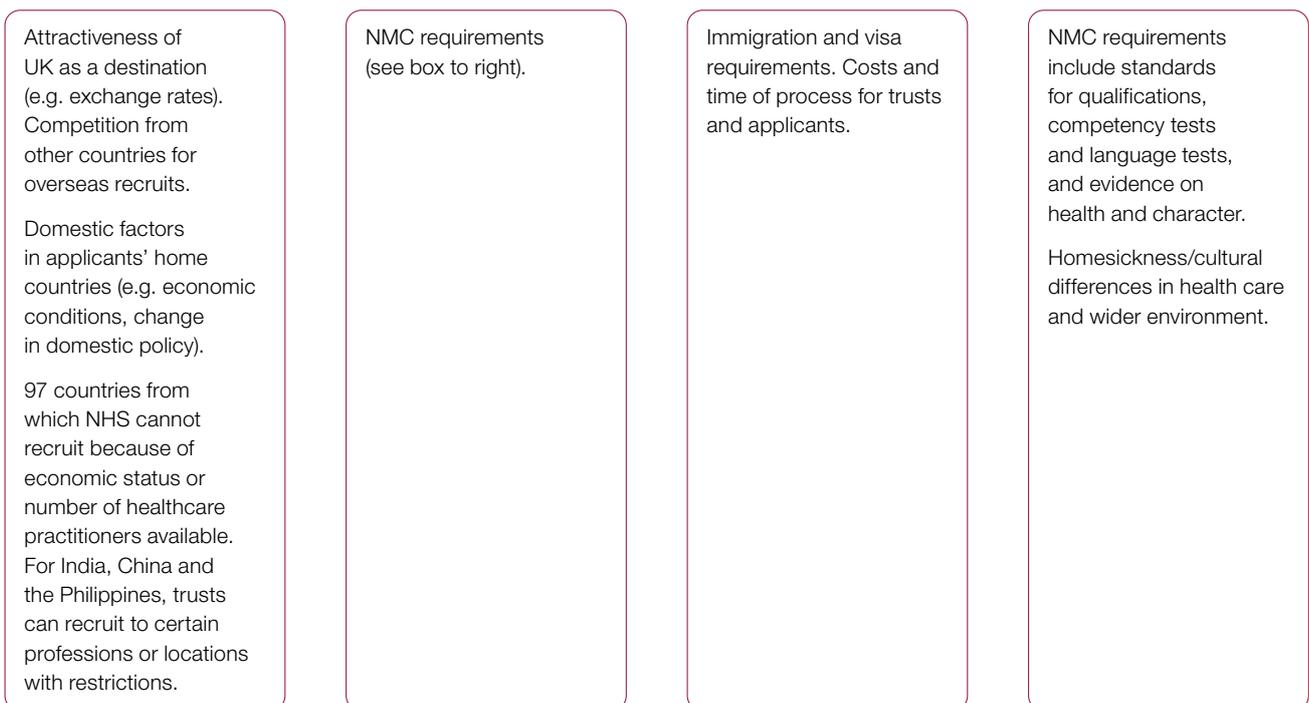
Factors affecting overseas recruits within NHS control



Key elements of overseas recruitment



Factors affecting overseas recruits out of NHS control



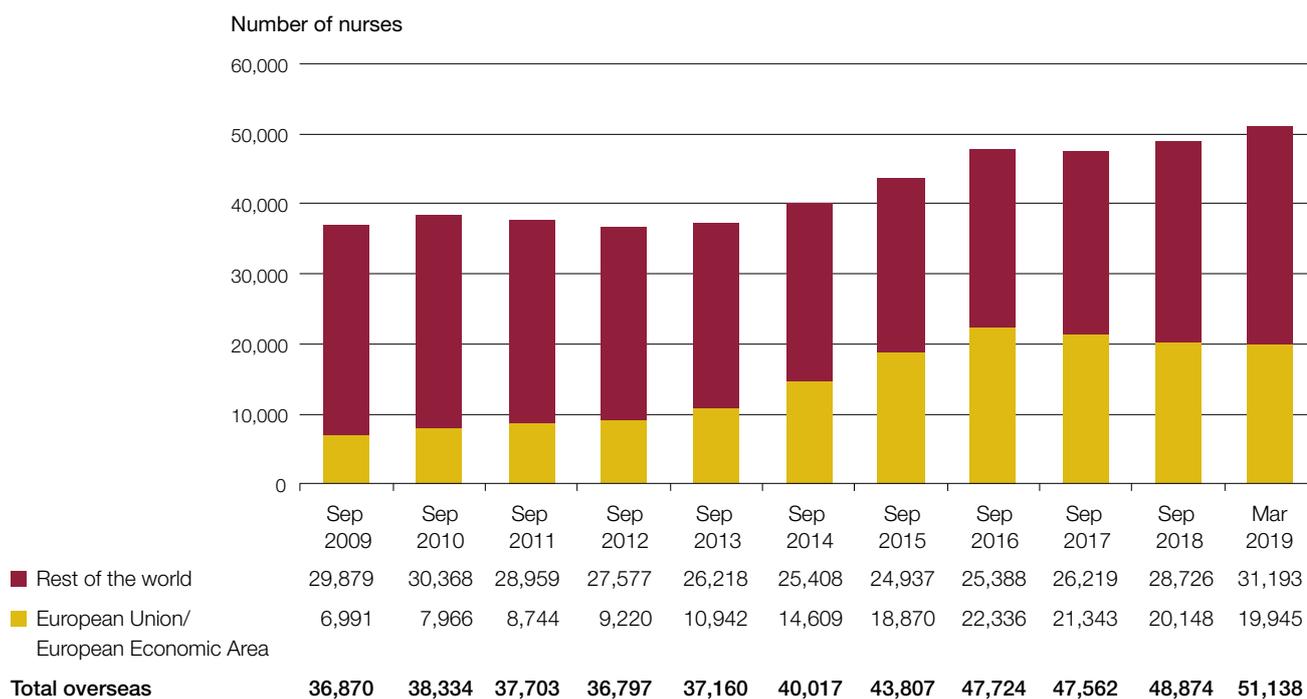
Source: National Audit Office analysis of Department of Health & Social Care, Nursing and Midwifery Council and Home Office information, and stakeholder interviews

2.20 Overseas recruits are a major source of new nurses, making up between a fifth and a quarter of all joiners since 2012. The number of overseas nurses working for the NHS has particularly increased in the past five years, rising by 28% from 40,000 in September 2014 to 51,000 in March 2019 (**Figure 14**). As a proportion of the workforce, this has remained fairly steady at between 14-17% since 2009 (17% as at March 2019). Three countries account for around half of non-UK nurses: the Philippines (25%), India (15%) and Ireland (9%). The number of nurses from the European Union increased steadily from 2009 to 2016, but then declined to around 20,000 (Figure 14). The fall in European Union nurses followed the June 2016 referendum result to leave the European Union, as well as the introduction of new language requirements in January 2016. Conversely, numbers from the rest of the world have increased since 2016, to around 31,000.³⁵

Figure 14

Numbers of NHS nurses from outside the UK, 2009–2019

Numbers of European Union nurses have dropped since 2016, while those from elsewhere in the world have increased



Notes

- 1 Excludes 'don't know's (which fell from 65,510 staff in 2009 to 15,324 in 2019), and primary care nurses. See footnote 35. Trend analysis includes around 300-400 health visitors a year joining from outside the UK.
- 2 The Total overseas figure differs to published NHS Digital data by one for September 2009, September 2012 and September 2013 due to the way that headcount totals are calculated.
- 3 Based on self-reported information from individual employees.

Source: National Audit Office analysis of NHS Digital data

³⁵ There are also high and changing levels of missing information, which complicate the interpretation of trends. This analysis excludes nurses whose nationality was not recorded, which made up 21% of all nurses in September 2009, decreasing to 5% in March 2019.

2.21 NHS Digital data shows that the proportion of overseas nurses varies from 30% to 36% in London regions to 5% to 8% in the north-east, north-west, and Yorkshire and Humber regions. Our visits confirmed variation in the use of international recruitment between regions and types of trust: two (one acute and one community trust) were actively planning to expand; one (acute) was already heavily reliant, while for three (two community and one acute) it was not currently a major source. To support trusts with international recruitment, the Department, NHSE&I and HEE are developing procurement frameworks and best practice guidance.

2.22 In the Interim People Plan, health bodies undertook to work with professional regulators to help improve and streamline regulation processes. From October 2019, the Nursing and Midwifery Council introduced an online application procedure, and streamlined the documentation requirements, for overseas nurses. In December 2018 and January 2020, following a consultation and review of the appropriateness of the required standards, it reduced the required pass grade for the written element of the language tests.³⁶ The Home Office has also exempted nurses from having to take a separate language test for immigration purposes, given the existing Nursing and Midwifery Council language requirements. In our visits, trusts emphasised the importance of supporting overseas recruits to pass the tests required for Nursing and Midwifery Council registration, as well as proactive pastoral care and support.

2.23 HEE lead a global learners programme that supports trusts to build relationships overseas and bring nurses to work in England who can return to their home country with improved skills. The programme missed its targets of appointing 1,000 nurses in 2018, achieving 600, and 1,500 nurses in 2019, achieving around 1,000. In 2018-19, around 100 of the nurses who were appointed subsequently withdrew. The programme has increased its targets to bring 15,000 nurses to England between 2020 and 2024.

Apprenticeships and nursing associates

2.24 Employers, supported by HEE, have developed a new apprenticeship-based route into nursing. Nursing degree apprenticeships have been available since 2017. In contrast to students on nursing degrees, healthcare providers employ nursing degree apprentices while they work and train, including external study at an approved education institution. Apprentices study for four years towards a nursing degree. At their launch, the government anticipated up to 1,000 nursing degree apprentices a year. In the academic year 2018/19, this expectation was met, with 1,041 people starting a nursing degree apprenticeship (up from 304 in the previous year).

³⁶ There was no change to the pass mark for other elements of the language tests (reading, speaking and listening).

2.25 In January 2017, a new nursing associate role was introduced, which bridges the gap between registered nurses and healthcare assistants. Although intended as a role in its own right, which can free up registered nurses to carry out more advanced roles, another aim was to develop a new route into nursing. Nursing associate training lasts two years and leads to a level 5 qualification (such as a foundation degree apprenticeship). To become a registered nurse, a nursing associate must study for around a further two years to 'top up' their qualification. From July 2019, courses for trainee nursing associates have to be approved by the Nursing and Midwifery Council. Based on a survey of the first trainees in the pilot phase, 47% said they intended to enrol on a nursing degree within one year. The evaluation also estimated an overall attrition rate of 16%.

2.26 HEE met its target for providers to recruit 5,000 trainee nursing associates in 2018 and expects to meet its target for 2019-20. The NHS Long Term Plan set a target of 7,500 in 2019 although the delivery date for the target was later changed to 31 March 2020. As at December 2019, HEE reported that providers had recruited 2,739 associates with a projection of 7,529 for the 15 months to 31 March 2020. It had put regional trajectories in place for each quarter, and was also liaising with the Nursing and Midwifery Council to take into account the timeline for individual universities to receive approval to provide courses.

2.27 All the local trusts we visited were planning to make more use of apprenticeships, primarily nursing associates. Perceived benefits included improvements in service areas where a clear nursing associate role had been identified; an alternative to degree routes appealing to a wider range of people; and better retention.

2.28 Larger employers (including NHS providers) must pay an apprenticeship levy, which they can use to pay for apprenticeship training and assessment. In 2018-19, NHS organisations spent less than 30% of their levy contributions. In our interviews with national bodies and local visits, we heard about barriers to wider roll-out, arising from the need to satisfy both higher education and healthcare regulation, which echoed those noted in a 2018 Education Committee report:

- **Use of the apprenticeship levy.** The Nursing and Midwifery Council requires apprentices to undertake at least 2,300 hours of clinical training, during which they must have 'supernumerary' status (ie they do not count as part of the staffing complement required for safe and effective care).³⁷ Trusts must therefore pay 'back-fill' costs for additional staff, but cannot use the levy for these costs. Four of the eight NHS providers we visited said this was a disincentive. The Council is allowing an alternative approach for trainee nursing associates, which does not require students to be supernumerary and which it will evaluate in due course. Stakeholders also raised issues about the levy funding not being able to cover supervisory costs or overseas recruits, and the fact that GP practices were not levy-paying employers.

³⁷ The Education Committee report noted that nursing degree apprentices must undertake off-the-job training for 50% of their hours, whereas the levy was designed to cover the cost of an apprentice undertaking off-the-job training for 20% of their contracted hours.

- **Complexity and costs of the process.** In our local visits, three out of four higher education providers said it was difficult to make apprenticeship courses sustainable, given factors such as the levels of scrutiny, bureaucracy and funding, and numbers of students. Some national bodies referred to a burden imposed by the requirement for apprentices to have both a Nursing and Midwifery Council registration assessment and a separate endpoint assessment, which the higher education provider requires to receive full payment.

Retention

2.29 As nurses' employers, NHS providers and GP practices are primarily responsible for day-to-day management of staff and therefore addressing any retention issues. In its oversight role for trusts, NHSE&I also provides support on retention. Some features of nurses' employment that may affect retention, principally pay and pensions, are set nationally.

2.30 Between 2012-13 and 2018-19, although the number of nurses joining the NHS increased, so did the numbers leaving: in the period September 2017 to September 2018, 31,000 nurses left the NHS, compared to a similar number who joined (**Figure 15** overleaf). The overall leaver rate increased from 9% in 2012-13 to 10% in 2017-18.³⁸

2.31 Historically, leaver rates vary by age, with highest rates expected for older people as they approach pensionable age. However, between 2012-13 and 2017-18, leaver rates for older age groups decreased, while rates for younger age groups increased. For example, the leaver rate for 55-59-year-olds reduced from 12% to 11%, while that for under 25-year-olds increased from 10% to 14%. Our analysis shows that, if the leaver rate of nurses aged under 55 had remained the same between 2012-13 and 2017-18, the NHS would have had 11,000 additional nurses in 2017-18.

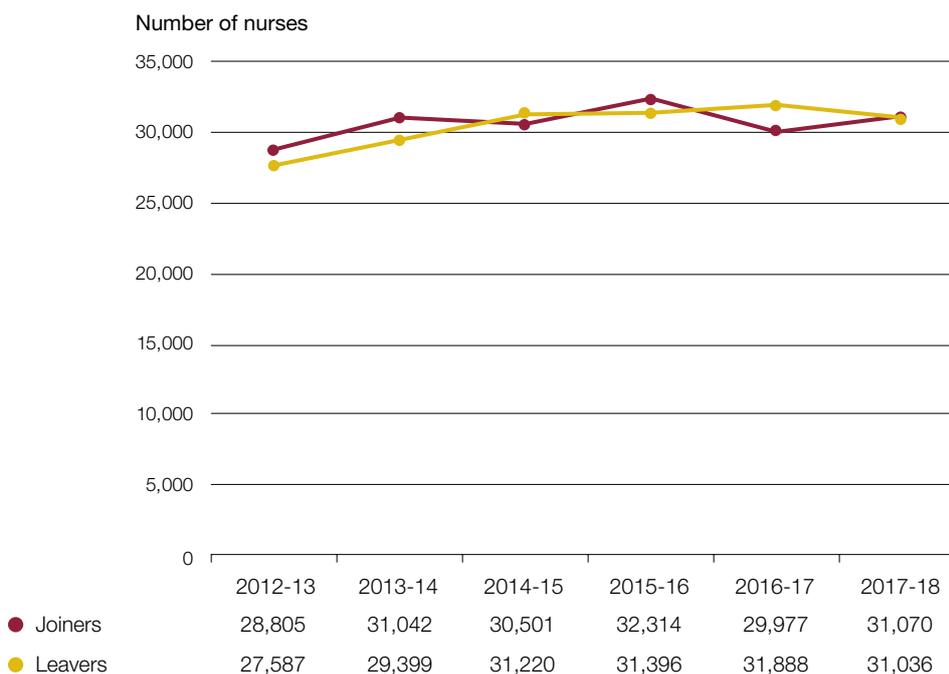
2.32 NHS Digital publish data on reasons for leaving, which, although they have relatively high levels of reasons that are unknown (26%), provide some insight into why nurses may leave mid-career. Based on nurses resigning from the NHS, the most common reasons given were relocation (26%) and work-life balance (21%, **Figure 16** on page 37). NHS Digital data were consistent with survey data on the reasons that nurses gave for leaving the Nursing and Midwifery Council register: younger age groups were more likely to cite leaving the UK, Brexit, poor pay, staffing and too much pressure. The NHS Staff Survey shows that 68% of nurses work additional unpaid hours each week and that health and well-being more generally have declined among NHS staff. In four out of seven discussion groups we held with nursing staff, we heard about workload pressures with staff having to work late or through breaks to meet their duty of care to patients, cover staff sickness or shortages, or deal with families.

³⁸ Leaver rates are calculated as the proportion leaving in a set period divided by the average number of staff at the beginning and end of that period.

Figure 15

Number of leavers from and joiners to the NHS, hospital and community services in England, September 2012–September 2013 to September 2017–September 2018

In 2017-18, approximately 31,000 nurses left the NHS, compared with a similar number who joined

**Note**

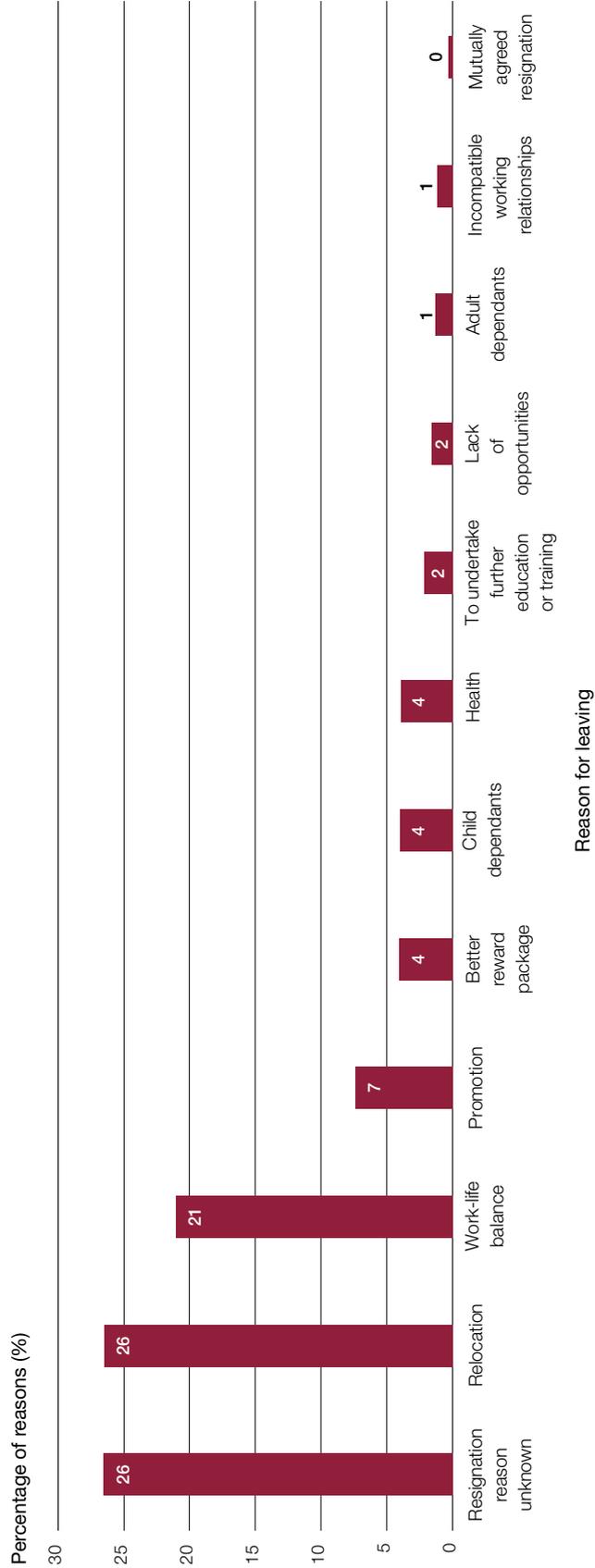
1 Headcount data. Excludes health visitors. Each period runs from September to the following September.

Source: National Audit Office analysis of NHS Digital data

2.33 The NHS nursing workforce as a whole is getting older, which means a higher proportion of nurses are closer to retirement: between September 2012 and March 2019, the proportion of nurses in hospital and community services aged 55 and over rose by 5% (from 12% to 17%). The NHS lacks good data to understand retirement but, based on NHS Digital data on reasons for leaving, around 20% of leavers said they were retiring. HEE modelling forecasts that approximately 41,000 nurses, or 13% of the workforce, will retire between 2018 and 2024. Our visits suggest that some trusts were working with older staff to work flexibly or on reduced hours as an alternative to retirement.

Figure 16
Reasons for leaving for nurses and health visitors resigning from the NHS in England, June 2017 to June 2018

The most common reasons nurses gave for resigning were relocation and work-life balance



Note

1 Based on approximately 14,000 nurses and health visitors resigning June 2017 to June 2018.

Source: National Audit Office analysis of NHS Digital data

2.34 Recognising this issue, since 2017, NHSE&I has run a retention support programme, which initially aimed to reduce nursing turnover rates in acute and community trusts, and clinical turnover rates in mental health trusts. It includes direct support to individual trusts to draw up their own plans and priorities to improve retention. NHS Improvement's analysis of trust plans identified eight main areas that these addressed, namely: career progression; health and well-being; understanding data; culture and leadership; support for new starters; flexibility; supporting experienced workforce (eg retire and return schemes); and trust brand. Most of these directly or indirectly address the reasons given by people leaving the NHS (with the exception of reward, Figure 16).

2.35 One of the programme's main metrics is the leaver rate.³⁹ Programme analysis showed that between March 2017 and March 2019, nurse leaver rates reduced by 0.6%, from 8.0% to 7.4%. The first group included in the programme, with the highest leaver rates, saw a bigger reduction (1.4% compared with 0.6% overall). The second group had a similar reduction (0.6%) and the third group saw a smaller reduction (0.3%).

2.36 The Long Term Plan commits to improving overall retention by at least 2% by 2025, which it states is the equivalent of 12,400 nurses. This figure of 12,400 is based on analysis of the NHSE&I's support programme. It assumes that nurse leaver rates will reduce by 1%, returning to between 2012-13 and 2013-14 levels, improvements continue for five years, and trusts with higher leaver rates make more improvement (1.9%). To date, overall performance has been better than predicted, although not for all individual groups.

³⁹ The programme's calculation of leaver rates differs from the rates published by NHS Digital. In particular, NHS Digital rates count those who cease to be paid for activity for potentially temporary reasons, such as maternity and other long-term leave, as leavers, whereas the programme's rates exclude them.

Part Three

The NHS People Plan

The Long Term Plan and implications for the nursing workforce

3.1 In June 2018, the Prime Minister announced a funding settlement for the NHS, which will see NHS England's budget rise by an extra £33.9 billion in cash terms by 2023-24. In January 2019, the NHS Long Term Plan set out what the NHS would deliver with this additional funding (**Figure 17** on pages 40 and 41). The plan contained a number of substantive service commitments (eg in cancer care and prevention of illnesses such as cardiovascular disease) and new models of working (eg in primary care). It recognised that workforce growth had not kept pace with demand, with the greatest shortfalls in nursing, and that achieving its service commitments required increases in the number of, and greater support for, NHS staff.

3.2 Prior to the Long Term Plan, Health Education England (HEE) published in December 2017 a draft workforce strategy on behalf of all NHS and public health bodies that noted pressures on the nursing workforce and stated that “despite the overall increase in [nurse] numbers, we still need to do more to meet increased demand”. It cited initiatives such as the pilots of the new nursing associate role and the retention improvement programme. That workforce strategy was never finalised and, by the time of the Long Term Plan, indicators such as the nursing vacancy rate had worsened.

3.3 The Long Term Plan stated a general ambition to increase the domestic supply of nurses over the next 10 years and in the short term signalled the need for a “step change in the recruitment of international nurses”. It made a number of quantified commitments for the nursing workforce – for example, to reduce the vacancy rate to 5% by 2028 and fund an additional 5,000 clinical placements from 2019-20, as well as wider staff commitments that are relevant for nursing (Figure 17). In December 2019, the government confirmed a pledge to increase the number of NHS nurses by 50,000 by 2025.

Figure 17

NHS Long Term Plan and Interim People Plan commitments relevant to nursing

The NHS aims to increase the domestic supply of nurses, with a range of specific and wider commitments in the Long Term Plan

Long Term Plan Commitments	Interim People Plan		
	2019-20 deliverables	Actions for full Plan	Commitments
Commitments specific to nursing			
Overall aim of reducing nursing vacancy rate to 5% by 2028 (through increasing number of undergraduate nursing degrees, reducing attrition from training and improving retention).			
Funding for additional 5,000 clinical placements from 2019-20; and up to 50% increase, from 2020-21.	✓		Actions to increase infrastructure, alongside further review.
Five-year NHS job guarantee for every nurse in region they qualify.		✓	Consider options for job guarantee approaches (for full plan).
New online nursing degree, with guaranteed placements (from 2020).		✓	Develop proposals for 'blended' learning programme.
7,500 new nursing associates in 2019, and investment in training to create meaningful career ladders. Terms of levy might need to change if NHS to provide opportunities to more clinical staff.	✓	✓	Support for STP/ICS in use of levy, alongside expansion of nursing associates pilot.
Explore 'earn and learn' support premiums for mental health or learning disability nursing, with aim of additional 4,000 people training by 2023-24.		✓	Review of actions required to support growth in mental health, learning disability and other shortage areas in nursing.
Two-year fellowship scheme for newly qualified nurses entering general practice.	✓	✓	Roll-out of voluntary fellowship. New set of actions for full plan to identify how to support growth in primary care workforce.
	✓	✓	Launch new return to practice in 2019-20 and develop clear model of entry routes to inform people plan.

Figure 17 continued

NHS Long Term Plan and Interim People Plan commitments relevant to nursing

Long Term Plan Commitments	Interim People Plan		
	2019-20 deliverables	Actions for full Plan	Commitments
Wider staff commitments relevant for nursing			
Annual campaigns in conjunction with Royal Colleges and trade unions for most urgently needed roles.	✓	✓	Consolidate existing campaigns and further review into high-need nursing areas.
New national arrangements to support NHS organisations in recruiting overseas.	✓		Development of procurement framework, best practice toolkit, and improvement of regulatory processes.
Extend Retention Collaborative to all NHS employers, and improve staff retention by at least 2% by 2025.	✓		Expand and extend existing programmes & provide additional support.
Increase investment in continuing professional development over the next five years (following Spending Review).		✓	Review, pending Comprehensive Spending Review.
Expand multi-professional credentialing - including development of credentials for mental health, cardiovascular disease, ageing population, preventing harm and cancer, with published standards in 2020.	✓		Develop standards and credentialing for specific areas and update Employment Staff Record to reflect advanced roles.
Shape modern employment culture for the NHS – promoting flexibility, wellbeing and career development, and addressing discrimination, violence, bullying and harassment.	✓		Local areas produce first set of plans.
	✓		Improvement of financial support for students through Learning Support Fund, and awareness of student finance package.

Source: NHS Long Term Plan and Interim People Plan

3.4 The Long Term Plan did not include detailed plans to ensure that the right workforce was in place to deliver the commitments. It set out that a workforce plan would be published later in 2019, following agreement of workforce education and training budgets (see paragraph 3.5). To develop the Long Term Plan, an early iteration of a national workforce supply–demand model developed by HEE was available and each service area also drew up workforce plans. We reviewed submissions for two areas, mental health and cancer, which showed the following:

- a** For mental health, there were indicative demand estimates of the staff required, broken down for nurses and by the service areas due to expand. With respect to cancer services, NHS England and NHS Improvement (NHSE&I) told us that demand estimates are primarily based on rises in the incidence and prevalence of cancer. In developing the Long Term Plan, it did not separately estimate the overall cancer nursing capacity required (ie from specialist or general nurses) and assumed that cancer needs would be met from the overall increase in the nursing workforce envisaged in the plan. Proposals noted the need for, but did not quantify, increases in specialist cancer nurses.
- b** There was no, or very limited, documentation of what actions the NHS would have to take for different service areas to understand whether the required workforce was achievable. For mental health nurses, the Long Term Plan did commit to explore “earn and learn premiums” to increase numbers but NHSE&I told us it subsequently ruled this out because of cost and implementation concerns.

3.5 The £33.9 billion funding settlement for the NHS only applied to NHS England’s budget, which would cover the costs of employing staff to deliver the Long Term Plan commitments. It excluded HEE’s budget – in particular, for workforce education and training. The Long Term Plan anticipated a five-year spending review in autumn 2019 to set these budgets for 2020-21 onwards, but this was replaced by a more limited spending round, with a fuller review rescheduled to 2020. This affected HEE budgets for:

- a** continuing professional development (CPD). Spending on CPD decreased sharply in 2016-17, and the Long Term Plan cited this as an important factor in retention. The spending round allocated a further £150 million to HEE for CPD for nurses (and other groups) in 2020-21.⁴⁰ This would raise funding back to 2014-15 levels (in real terms) (**Figure 18**).
- b** funding of clinical placements, that nursing students must undertake as part of their degree. At the time of the Long Term Plan, HEE had access to further funding to deliver an additional 5,000 clinical placements in 2018-19 and 2019-20, which was subsequently extended to 2020-21. For 2018-19, HEE did not draw down any additional funding; it estimated that, if required, this could amount to around £5 million.

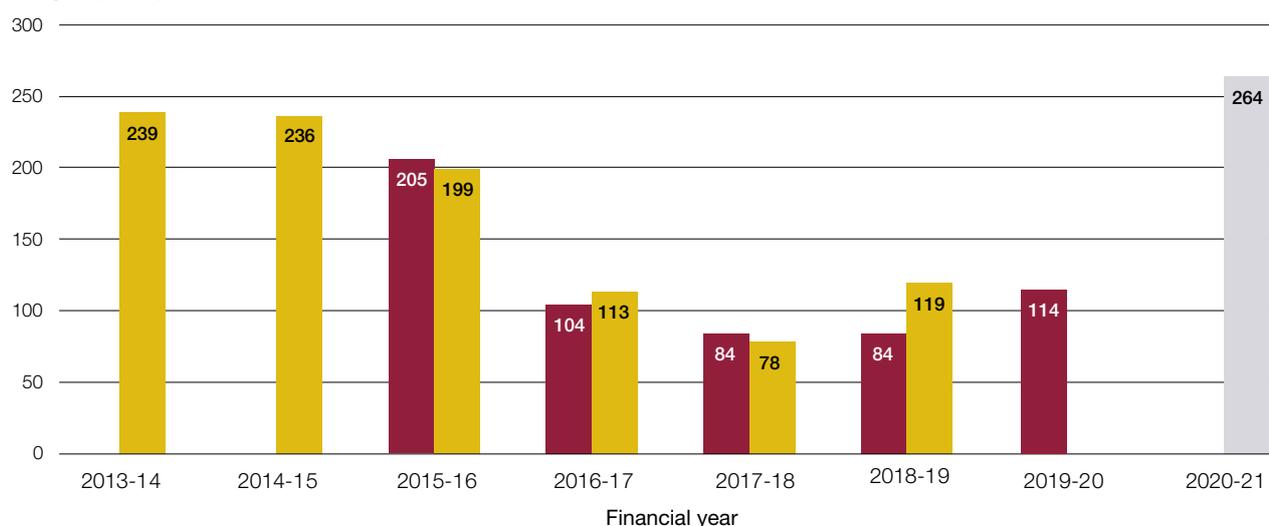
⁴⁰ At the time of writing this report, HEE was awaiting formal confirmation of the £150 million funding from the Department. As set out in the spending round, this would be based on a per head budget of £1,000 over three years for each nurse, midwife and allied health professional.

Figure 18

Health Education England workforce development: budget, spend and spending round estimates, 2013-14 to 2020-21

The 2019 spending round raised 2020-21 funding on continuing professional development back to 2014-15 levels (in real terms)

Budget/spend (£m)



- Budget (£m)
- Spend (£m)
- Spending round 2019 (£m)

Notes

- 1 Figures are shown in cash terms.
- 2 The spending round estimate assumes the 2019-20 budget plus an additional £150 million.

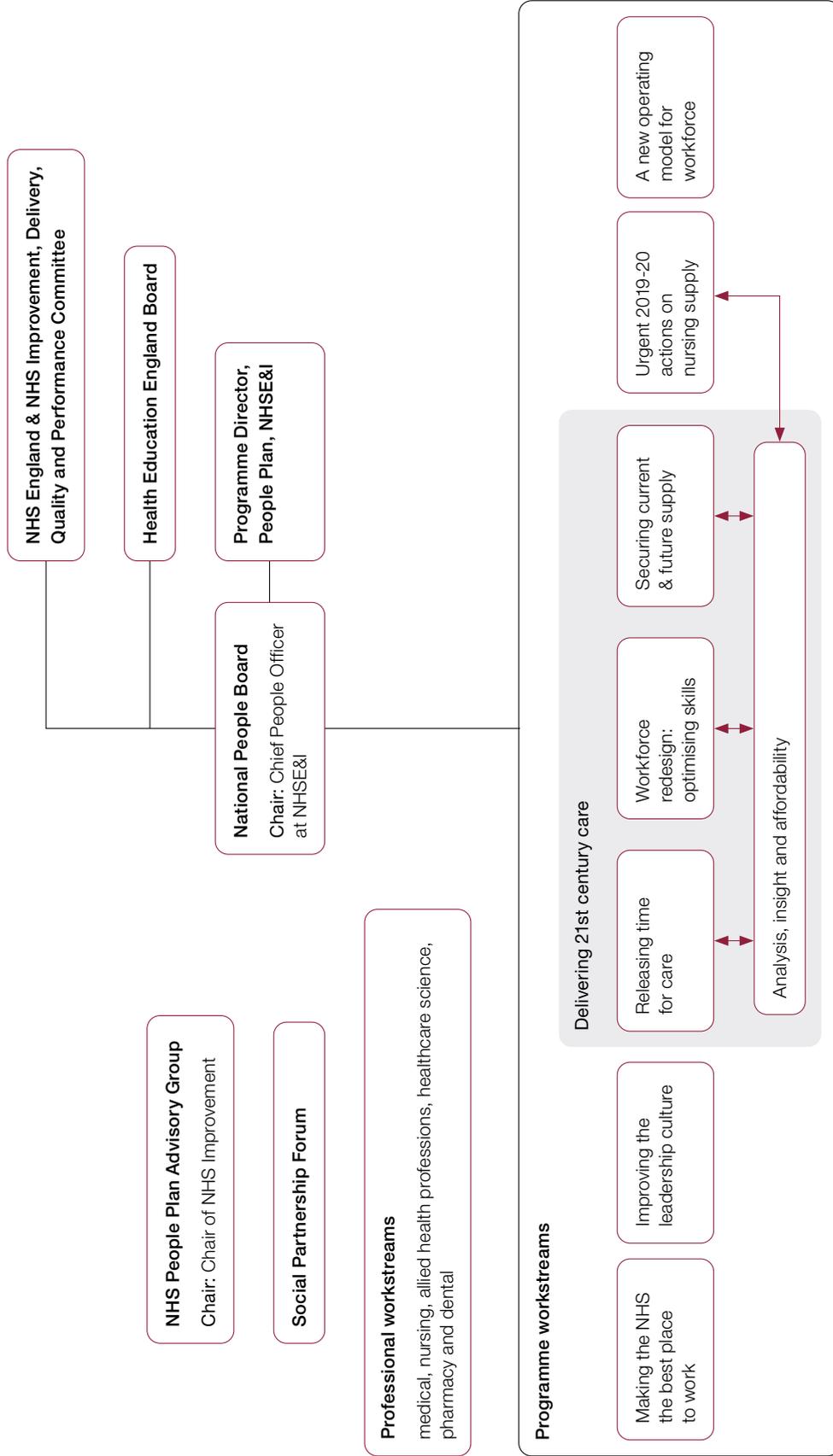
Source: National Audit Office analysis of Health Education England annual accounts and business plans, and spending round summary

The supporting People Plans for the Long Term Plan

3.6 In the Long Term Plan, the NHS committed to publish a full People Plan later in 2019. NHSE&I, HEE and the Department established cross-body governance for this programme. The chief people officer at NHSE&I chairs the National People Board overseeing development of the People Plan, which includes representatives from all the major health bodies. Underpinning this are eight workstreams, including a dedicated workstream on nursing supply (**Figure 19** overleaf). As well as representatives from national NHS bodies, the nursing supply group includes a wide range of stakeholders from the Royal Colleges, higher education, NHS trusts and trade unions.

Figure 19
Governance of the NHS People Plan programme

NHS England and NHS Improvement, Health Education England and the Department of Health & Social Care have established governance structures for the People Plan programme supporting the Long Term Plan



Source: NHS England and NHS Improvement documentation

3.7 In June 2019, the NHS published an Interim People Plan with actions for 2019-20.⁴¹ This highlighted further actions targeted at, or relevant to, nursing (eg about return to practice or recruitment campaigns, Figure 17). The majority of actions involved further review or development to lay foundations for later changes; others, like an increase in university places, might result in changes in three to four years, and would not have an immediate impact on nurse numbers.

3.8 HEE and NHSE&I have separate routes for monitoring progress against the Interim People Plan. NHSE&I reports progress on a quarterly basis to its internal people committee against the interim actions it is leading on, as well as the actions that HEE is leading with NHSE&I's support.⁴² The Department also monitors progress against some of the interim actions that HEE is leading and overall progress towards the full People Plan through quarterly accountability meetings, but it does not systematically monitor progress against all the actions in the Interim People Plan. National People Board papers do not systematically track progress against targets or deliverables for individual workstreams or Interim People Plan commitments, or overall progress of the work against milestones.

3.9 The Interim People Plan included an aim to publish a full, costed five-year People Plan in 2019. NHSE&I and HEE did not meet this commitment and the programme has been delayed in part by the replacement of the autumn 2019 spending review by a one-year spending round, and the December election, including the associated pre-election restrictions on government activity from November.⁴³ The full People Plan covering the period 2019–2025 is now due to publish in spring 2020. NHSE&I told us that this plan will be refreshed annually.

3.10 The Interim People Plan set out that the Long Term Plan and full People Plan would provide the basis for an overall workforce strategy. NHSE&I told us that the governance structures will be reviewed after the full People Plan, which will set out each organisation's responsibilities for future delivery of the plan. The spending round in September 2019 allocated £60 million to People Plan activities for 2020-21, and NHSE&I told us the National People Board would be responsible for prioritising which national actions to undertake. The Department told us that it will use metrics to track progress in delivering the plan. In February 2020, it also established a central programme board aiming to coordinate the government's strategy, policy and delivery of the commitment to provide 50,000 more nurses.

3.11 NHSE&I and HEE are jointly developing an overall model of supply and demand of nurses to the NHS to support the People Plan. This primarily covers NHS-employed nurses in hospital and community services. It excludes primary and social care, as well as other nurses who may provide NHS services such as agency or bank staff.⁴⁴

41 This report does not evaluate the People Plan process or progress against the Interim People Plan.

42 The NHSE&I People Committee is a sub-committee of NHSE&I and HEE's boards.

43 During an election campaign, there are restrictions in place on what the government can do. The restrictions cover activities such as initiating new policies, announcements and communications and extend to arm's-length bodies such as NHSE&I and HEE.

44 NHSE&I told us that, since our review, the model has been extended to cover primary care.

3.12 There is a significant time lag before policies to train new nurses can have impact. For example, in relation to undergraduate degrees, the announcement of maintenance grants in December 2019 came a month before the closure of applications for September 2020 courses. These students will graduate in 2023 at the earliest, in the final year of the funding settlement period. This increases the reliance on strategies such as overseas recruitment, improved retention and reducing attrition from training, which can have more of an immediate impact.

Local partnership plans

3.13 In June 2019, NHSE&I set out what approach local partnerships (that is, sustainability and transformation partnerships or integrated care systems) should take to create five-year strategic plans to implement the NHS Long Term Plan.⁴⁵ This is an essential element in ensuring that local planning and actions are compatible with national ambitions and targets, including for the nursing workforce.

3.14 With respect to workforce, the guidance instructed partnerships to set out *“realistic workforce assumptions, matched to activity and their financial envelope”*. Plans had to include:

- a** planned growth in workforce numbers, including separate estimates for nursing staff in trusts and general practice;
- b** local actions to improve retention, international recruitment and use of the Apprenticeship Levy;
- c** how partnerships would ensure that efficiency and productivity plans include actions to improve workforce efficiency and release greater time for care; and
- d** changes to local workforce operating models, to develop capacity, capability, governance and ways of working. This specifically included prioritising urgent action on nursing shortages.

3.15 Local partnerships submitted their draft plans to NHSE&I in September 2019, with final plans due to be published in November 2019. As at March 2020, these plans were yet to be published.

Appendix One

Our methodology

Scope

1 On the basis of evidence we collected between April and November 2019, this report sets out the facts on:

- the scale of the NHS nursing workforce challenge;
- challenges to the main entry routes to NHS nursing, and more general workforce-related challenges, that any future plans will need to address; and
- progress made on the NHS People Plan. This report does not evaluate the People Plan process or progress against the Interim People Plan, or supporting processes such as the modelling of nursing supply and demand.

Methods

2 We spoke to a range of staff across the Department of Health & Social Care (the Department), NHS England and NHS Improvement (NHSE&I) and Health Education England (HEE). This was to understand roles and responsibilities for workforce planning and supply; the development of the NHS Long Term Plan and supporting People Plans; ongoing analysis, work and initiatives relating to nursing supply and demand; and performance and management of routes into nursing. We also interviewed staff at the Department for Education.

3 We reviewed and analysed a wide range of documentation from the Department, NHSE&I and HEE. This included:

- the Long Term Plan, Interim People Plan and supporting papers, minutes and analysis for the National People Board and People Plan teams, along with descriptions of governance structures;
- for Long Term Plan commitments relating to mental health and cancer care, submissions and supporting documentation relating to workforce commitments;
- published guidance including on Long Term Plan implementation, safe staffing and workforce safeguards;

- NHSE&I's retention improvement programme overviews, papers and progress reports;
- Department deep dives on nursing and minutes and papers from the Nursing Supply Board;
- progress reports, papers and documentation relating to funding and expansion of clinical placements; and
- performance and progress reports on international recruitment and nursing associates programmes.

4 We examined documentation of the model of nursing supply and demand being developed by HEE and NHSE&I. We examined documents relating to the main supply model, which was based on existing work by HEE. However, we did not review other components of the model, namely the demand model or estimates of the impact of potential actions to increase supply.

5 We accessed and analysed NHS Digital data on the nursing workforce.

These included:

- trends and patterns in the nursing workforce by trust and care setting, nursing specialism, region and socio-demographic characteristics such as age, gender and nationality;
- socio-demographic profile of the nursing workforce;
- trends and patterns in turnover, leaver and joiner numbers and rates; and
- other datasets including earnings data; bank nursing staff; reasons for leaving; vacancy indicators and sickness absence statistics.

6 We accessed and analysed data from other bodies, principally:

- Nursing and Midwifery Council registration and revalidation statistics, and its survey of people leaving the register;
- University and Colleges Admission Service (UCAS) published data and data provided to national health bodies, including trends and patterns in nursing degree applicants and acceptances; and
- Higher Education Statistics Agency (HESA) published data on nursing degree graduates.

7 We visited four local areas (south-west London; Kent; Teeside and Northamptonshire) between August and September 2019. This work was designed to understand local roles and responsibilities for workforce planning; the main challenges for nursing recruitment and retention; local workforce planning and interventions; and interactions with regional teams and national bodies. In each local area we included two NHS providers (either acute, community or mental health), and spoke to staff with responsibilities for nursing and workforce planning; one university; sustainability and transformation partnership staff, including local workforce action boards; and local HEE teams. Where possible, we spoke to the regional NHSE&I team and people with responsibilities for primary care workforce planning, and carried out discussion groups with nursing staff. We selected areas and trusts with contrasting characteristics and experiences, as indicated by: NHS England's July 2017 ratings of progress for sustainability and transformation partnerships; geographic location; trusts' financial performance; levels of nurse turnover, leavers, joiners and sickness absence; Care Quality Commission assessments of system working; and trends in numbers of new nursing students since 2017.

8 We interviewed a range of health and higher education stakeholders, and accessed relevant analysis and documentation from them. This work was designed to get views on main challenges to, and interventions designed to improve, nursing recruitment and retention; and identify other relevant data, analysis or reports on nursing supply and demand. We consulted with:

- professional and sector regulators: the Nursing and Midwifery Council; the Care Quality Commission; and the Office for Students;
- professional and staff bodies: the Royal College of Nursing and Unison;
- health sector stakeholders: NHS Providers; NHS Employers; the King's Fund; the Nuffield Trust; and the Health Foundation;
- higher education stakeholders: Universities UK; and the Council of Deans of Health. We also spoke to staff at Oxford Brookes University and the University of Roehampton; and
- other stakeholders: the Office for Manpower Economics.

9 We reviewed previous National Audit Office reports on workforce planning and supply. This identified what workforce-related challenges other government bodies had experienced. Appendix Two sets out the reports we reviewed.

Appendix Two

Challenges to workforce planning and supply

1 The National Audit Office has carried out a number of workforce studies that, in the past five years, include ones on the NHS, adult social care, the military, teachers, the Civil Service and the BBC. All these studies found common challenges in difficulties with recruiting and retaining staff; underperformance of workforce initiatives to address these; and managing the impact of shortages on existing staff.

Figure 20

Examples of common challenges to workforce planning and supply¹

National Audit Office Report	Accountability		Workforce planning			
	Responsibilities and accountabilities	National oversight	Understanding future needs	Understanding supply	Overall plan	Reliable information
Managing the supply of NHS clinical staff	●	●	●			●
Improving patient access to general practice			●			●
The adult social care workforce	●	●	●	●	●	
Army 2020			●	●	●	
Ensuring sufficient skilled military personnel	●	●	●	●		
Reforming the civilian workforce			●		●	●
Training new teachers			●	●	●	●
Retaining and developing the teaching workforce	●		●	●		●
Managing the BBC's workforce		●		●		
Capability in the civil service			●	●	●	●

Note

1 References for NAO reports in the table are as follows: Comptroller and Auditor General, *Managing the supply of NHS clinical staff in England*, Session 2015-16, HC 736, National Audit Office, February 2016; Comptroller and Auditor General, *Improving patient access to general practice*, Session 2016-17, HC 913, National Audit Office, January 2017; Comptroller and Auditor General, *The adult social care workforce in England*, Session 2017-2019, HC 714, National Audit Office, February 2018; Comptroller and Auditor General, *Army 2020*, Session 2014-15, HC 263, National Audit Office, June 2014; Comptroller and Auditor General, *Ensuring sufficient skilled military personnel*, Session 2017-2019, HC 947, National Audit Office, April 2018; Comptroller and Auditor General, *Reforming the civilian workforce*, Session 2017-2019, HC 1925, National Audit Office, March 2019; Comptroller and Auditor General, *Training new teachers*, Session 2015-16, HC 798, National Audit Office, February 2016; Comptroller and Auditor General, *Retaining and developing the teaching workforce*, Session 2017-2019, HC 307, National Audit Office, September 2017; Comptroller and Auditor General, *Managing the BBC's workforce*, Session 2016-17, HC 1133, National Audit Office, April 2017; and Comptroller and Auditor General, *Capability in the civil service*, Session 2016-17, HC 919, National Audit Office, March 2017.

Source: National Audit Office analysis of published reports

2 Figure 2 in the Summary sets out the general challenges we have observed in workforce planning and the implementation of workforce initiatives. **Figure 20** shows how these link to published reports on workforce.

Integration with finance and performance	Coverage of all staff	Workforce supply					Addressing short-term shortfalls	
		Planning for training places	Funding arrangements	Addressing differences in challenges	Support for local bodies	Cross-government policies	Approach to filling shortfalls	Managing competition
		●	●	●		●	●	●
		●		●	●		●	
			●	●		●	●	●
●			●	●				
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