7-Point Plan Nursing Review Group:

Final Report

November 2020

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Executive Summary

About this report

The challenge of responding to COVID-19 in other countries, such as Italy, made it clear that the NHS would need to respond at speed and before a detailed plan could be drafted. The need for additional staff in hospitals led the Chief Nursing Officer (CNO) for England to write to the NHS on April 6th, 2020 setting out seven actions that would increase nursing and midwifery capacity.

The NHS responded to the unprecedented demand quickly and the CNO sought to review the impact of the seven actions through a 7-Point Plan Review Group. The Terms of Reference (ToR) of the group were approved by the National Incident Response Board (NIRB) on the 29th April 2020. The objectives of the review were:

1. To review the operational delivery of the 7-point plan, to identify blockages and make recommendations for immediate improvement

2. To review readiness of the profession for potential future waves of COVID-19, taking into consideration learning from the first wave, making recommendations for any changes or extensions to the plan.

3. To consider the professional challenges for nursing and midwifery during the recovery period as the NHS manages both COVID-19 and non-COVID-19 services across the system.

Our findings

The Review Group recognises the challenging circumstances and pace at which the plan was issued. Whilst acknowledging this, our terms of reference require us to establish if the plan was the right plan and whether it included adequate operational detail to ensure its implementation was as effective as possible. We have also considered if the plan met the needs of providers and systems, and how operational issues of the plan were considered including risk and accountability. We recognise that, despite the pressure to develop and deploy initiatives quickly, the CNO consulted with stakeholders to agree the action to be taken.

The review group has not seen the demand-side modelling undertaken to forecast the required workforce needed for different planning scenarios, but it was clear that all would require significant numbers of additional staff. Our findings are that increasing the workforce was predicated on mobilising the greatest number of nursing staff to support the NHS response rather than increasing capacity based on the demand modelling. Given the urgency and changing picture, the review group recognise this as an appropriate approach. Although the demand modelling forecast a high number of patients requiring O2, O2+ and mechanical ventilation, the skills and competencies required to meet this demand were not specifically considered in the nursing mobilisation plan, nor was any consideration given to staggering the recruitment to prioritise the needs of different parts of the health system. This was particularly noticeable in relation to the temporary register, meaning those returners with critical care skills were not identified and mobilised at the point of peak critical care demand.

Overall, our fieldwork indicated that the seven initiatives identified to increase supply were appropriate to increase the total capacity of registered nurse and midwifery numbers. However, the system for enacting the plan did not indicate the relative importance of each of the seven initiatives and did not always work smoothly. Our fieldwork found that key stakeholders in the system were familiar with the individual components of the 7-point plan, but more could have been done to ensure a single, cohesive operational plan. We heard of inconsistencies and ambiguities between the messaging of the CNO and CPO teams. We also heard that communication with temporary registrants was infrequent and did not explain

the delays in their deployment and that this may have increased attrition from the process. In order to understand the impact of the plan, a comprehensive dataset and monitoring mechanism would have provided the CNO with the information to adjust the plan where needed.

Most providers reported that they increased their capacity through redeploying existing staff and we heard good examples of system working to support provider responses, helped by stopping elective work and a reduction in public access to emergency care. However, we conclude that future waves of demand are unlikely to be able to access this staffing source to the same extent given other services are unlikely to be stopped so fully. Future plans should therefore seek to increase the overall numbers of registered nurses available to the NHS.

The deployment of nursing students, despite some communication and matching challenges, resulted in widely reported positive experiences for students and providers. Their deployment has provided an important opportunity for HEIs, HEE and the NHS to build improved relationships. However, despite this largely positive outcome, there is little appetite to consider future mobilisation of nursing students for future waves due to the impact on students' education.

A low percentage of the eligible former nurses joined the temporary register. We heard that the centrally managed employment checks process was slow and the number of temporary registrants who made it into practice was low. Engagement with returners to understand their motivation and what they wanted to contribute was felt to be, at best, patchy. There appeared to be little focus on increasing the number joining the temporary register or engagement with those currently on the temporary register, despite this route having the largest potential supply. We believe that getting the temporary register right is key to the response in future waves. Central to this are two things: understanding and improving the experience of returners themselves and listening to providers and local systems. We conclude that a more locally owned process for handling employment checks and deployment of returners may help in both regards. We recognise that all of this was undertaken in a rapidly changing and fast-moving response to an unprecedented set of circumstances.

Our recommendations

We have made a number of recommendations covering:

- How the 7-point plan could be operationalised more strongly and clearly
- The role of risk assessment and data monitoring to better make and review evidenced based decisions
- Improving the scaling and deployment of additional members of the nursing workforce

In considering our recommendations we have considered two timeframes: actions we believe should be taken now to improve the response for a second wave of COVID-19 and longer term actions which may have a longer lead in time but which we think should be considered to support future pandemic planning:

Recommendations to support future COVID-19 response:

- Risk assessments should follow a national framework, with version control, date of agreement and author details.
- Greater focus should be placed on clarifying accountability for specific actions.
- All communications should routinely be routed through the Incident Coordination Centre, with consistent and wider distribution lists reflecting the nursing and people responsibilities in operationalising a workforce plan.

- Minimum data sets monitoring the impact of actions should be agreed and communicated through the ICC. Where data is required from other ALBs or stakeholders this should be clearly agreed, documented and provided through a single route.

- Future workforce plans should be underpinned by risk assessments which address the impact on existing staff, returners and patients and should adhere to national pandemic risk assessment guidelines. The risk assessment should inform the prioritisation of different elements of the plan.

- Plans should include clear roles and responsibilities for implementation and communication, considering the role played by stakeholders at national, regional and local levels. This should include accountability for both delivering the plan and monitoring its efficacy.

- National minimum data sets on the recruitment and deployment of additional staff in a pandemic should be agreed.

- National guidance on the support required by registered nurses deployed through the Rapid Response Service should be provided.

- The CNO should:

  - Work with stakeholders to understand why the numbers attracted to join the register were significantly lower than the number eligible;

  - Resolve who has accountability for contacting returners and commission a review of returner experiences to help shape a more effective and efficient deployment process, inform future communication strategies, reduce variation in onboarding and understand more about their personal experiences.

- More responsibility for operationalising and deploying staff from the temporary register (including pre-employment checks) should be delegated to local systems. This may enable the better matching of skills to clinical areas based on local need.

- Consideration should be given to using NHSP to support pre-employment checks at a local level.

- Consider using greater stratification of the recruitment to the temporary register, focusing on skills most needed at any given time.

- Consider specific communications from the CNO to existing nurses and midwives on the temporary register, and potential eligible returners, in addition to communications from the BBS campaign to maximise professional traction and engagement.

- A minimum dataset that provides sufficient detail to monitor the supply of additional nursing staff in future responses should be agreed nationally and deployed across the system.

- Meaningful data should be used to review and refine the plan for future waves.

Recommendations to support future pandemic planning:

- We recommend that the CNO office work with the NMC to complete further analysis of the skills and availability of nurses on the permanent register but not employed by the NHS so that informed decisions can be taken as to whether this cohort should be specifically targeted (and if so, how) in future waves.

- Separate assessments for increased midwifery capacity (for example, to cover illness and those shielding) to be performed in future and discrete actions to be developed.

- Future plans should have a greater emphasis on identifying specific skills required at different stages of a pandemic and consider how this might modify the call for additional staff. This includes a recommendation for greater emphasis on all sectors of the health system (e.g. mental health, community services)

- NHSE/I should consider the development of a specific nursing workforce mobilisation plan as part of its overall Pandemic Plan. This should be developed jointly by the CPO and CNO teams with frontline engagement, including with staff who joined the temporary register.

- When considering approaches for increasing the workforce for future waves or pandemics, consideration should be given to the disruption of nursing students' education and should not impinge on the student trajectory towards completion and permanent registration with the NMC.

1. Introduction

1.1 Purpose of this report

The challenge of responding to COVID-19 in other countries, such as Italy, made it clear that the NHS would need to respond at speed and before a detailed plan could be drafted. The need for additional staff in hospitals led the Chief Nursing Officer (CNO) for England to write to the NHS on April 6th, 2020 setting out seven actions that would increase nursing and midwifery capacity.

The NHS responded to the unprecedented demand quickly and the CNO sought to review the impact of the seven actions through a 7-Point Plan Review Group. The Terms of Reference (ToR) of the group were approved by the National Incident Response Board (NIRB) on the 29th April 2020. The Review Group had an independent chair and vicechair (full details of review group members can be found in **Appendix A**). The group met virtually throughout to set the direction of the review and receive evidence from the fieldwork conducted by the secretariat provided by EY. The objectives of the review were:

1. To review the operational delivery of the 7-point plan, to identify blockages and make recommendations for immediate improvement

2. To review readiness of the profession for potential future waves of COVID-19, taking into consideration learning from the first wave, making recommendations for any changes or extensions to the plan.

3. To consider the professional challenges for nursing and midwifery during the recovery period as the NHS manages both COVID-19 and non-COVID-19 services across the system.

1.2 Approach to the fieldwork

During the first phase of the review, the secretariat undertook a series of semi-structured interviews with all members of the review group. The observations from these interviews formed the basis of the key lines of inquiry and hypotheses that were tested more widely during the latter part of the review. The overarching propositions identified in phase 1 were:

- The establishment of the temporary register was useful in increasing capacity. However, the process for mobilising staff into roles was complicated and inefficient;

- The plan lacked flexibility, operational detail and monitoring mechanisms inhibiting the ability to evolve the plan based on changing needs throughout the system;

- The initial communication of the plan was clear and well-received; however, subsequent communication was perceived as disjointed and inconsistent;

- Where there was an existing relationship with agencies, such as NHS Professionals, it worked very well; however, where this was not the case this initiative was ineffective;

- There was a lack of focus on risk assessments to underpin the plan.

A variety of sources were used to obtain evidence to understand how the 7-point plan was designed and implemented:

- 26 individual interviews with national and regional leaders involved in the design and delivery of the plan as well as key stakeholders;

- 11 focus groups including regional, systems and providers as well as staff and students who responded to the plan. These focus groups included 38 nurse leaders from provider, commissioner and ICS roles. Focus groups were not conducted with returners to the

temporary register, nurses still on the register but not employed by the NHS, or substantive NHS staff who were redeployed;

- Analysis of longitudinal data collected by the Nursing and Midwifery Council (NMC), Health Education England (HEE) and the Bring Back Staff (BBS) campaign;

- A supplementary questionnaire sent to a sample of DoNs and returned by 11.

All field work was conducted between 29th June to 6th August. Our findings are therefore based on the information available and provided during this timeframe.

1.3 Recommendations from interim report

Our interim report to the CNO on 18th June, made several recommendations for strengthening the NHS response to the pandemic. These were:

- Shift the focus from the acute setting to build nursing capacity across the whole system;

- Ensue nursing students receive the appropriate contracts from providers, including indemnity cover and death in service cover;

- Assess the health and wellbeing of the current workforce responding during the first wave to increase assurance that sufficient workforce was in place for subsequent waves;

- Understand and address the legal issues, such as indemnity, affecting support into the care home sector to ensure an efficient and consistent approach to how staff can work in non-NHS organisations;

- Ensure that the voice of the nursing profession was heard in addressing the impact of COVID-19 on BAME communities, including staff.

We have received evidence from the CNO on a range of actions taken by NHS England and its partners in response to our recommendations.

2. Background

2.1 Background and context

COVID-19 was declared by NHS England to be a Level 4 National Incident on 30th January 2020. The pandemic presented extreme operational, clinical, and logistical challenges for the NHS, social care and the government. Evidence from other countries, as well as advice from SAGE, indicated that NHS hospitals would experience intense pressure and this would be further exacerbated by staff shortages due to sickness, shielding and caring responsibilities. In order to be able to respond to the pandemic, the NHS needed to invoke contingency plans to increase in patient capacity, particularly in critical care, especially for ventilated care.

The nursing and midwifery workforce make up the largest group of registered healthcare professionals, and international insights indicated that the nursing workforce capacity would need to significantly increase to respond to the pandemic at the scale required. 2019 data from NHS Digital indicated that the nursing vacancy rate in England was 10.7% (equivalent to 38,785 FTE vacant posts); therefore, the impact and pressure of the pandemic would be felt by an already depleted workforce.

2.2 Demand modelling

The review group has not seen the demand-side modelling undertaken to forecast the required workforce needed for different planning scenarios, but it was clear that all would require significant numbers of additional staff. Our interviews, undertaken with national leaders, indicate that increasing the workforce was predicated on mobilising the greatest number of nursing staff to support the NHS response rather than increasing capacity based on the demand modelling. Given the urgency and changing picture, the review group recognise this was an appropriate approach. We heard that the demand modelling that did take place was not shared with the regions and this may have hampered their ability to undertake more detailed local planning.

Although the demand modelling forecast a high number of patients requiring O2, O2+ and mechanical ventilation, the skills and competencies required to meet this demand were not specifically considered in the nursing mobilisation plan, nor was any consideration given to staggering the recruitment to prioritise the needs of different parts of the health system. This was particularly noticeable in relation to the temporary register, meaning those returners with critical care skills were not identified and mobilised at the point of peak critical care demand.

2.3 Development and operationalisation of the 4 and 7-point plans

The 7-point plan was an update to an earlier letter dated 19th March 2020. We detail the chronology of communications and decisions leading up to the 7-point plan in more detail in **Appendix B.** We detail the events that lead to the deploying of nursing students in **Appendix C.**

Three meetings with the four CNOs of the UK, together with representatives from the Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN), Royal College of Midwives (RCM), Unite, UNISON, Council of Deans of Health (CoDoH), Health Education England (HEE), NHS England and Improvement (NHSE/I), and Department of Health and Social Care (DHSC) were held on the 12th March and 16th March (morning and evening), to discuss how to use the temporary nursing and midwifery register (once opened by the NMC following the passing of emergency legislation). We have not seen the minutes from these three meetings and have instead been informed by one-to-one interviews with those who attended (explored in further detail later in this report).

On the 19th March 2020, the CNO sent a letter to Regional Chief Nurses and Directors of Nursing (DoNs) outlining four actions that were being considered for expanding the existing nursing workforce capacity. The letter was not copied at that time to HR directors either in the NHSE/I regional teams or in provider organisations. It has been a recurring theme in our field work that communication during the March/April period was described as overwhelming with multiple letters and guidance coming through routes outside of the main incident response centres to multiple copy lists, leading to some confusion and ambiguity about what was being requested and who was responsible for leading it. We were told that this seems to have added to an impression that the CNO and CPO teams were not always aligned.

The CNO's 4-point letter, stated that:

- Once the government legislation to enable the NMC temporary register was passed, the initial focus of the NMC would be to invite those who had left the register within the last three years to join;

- There would be a focus on encouraging skilled individuals who were currently on the register but in non-clinical roles into clinical roles to support during the pandemic;

- There would be changes to the programme for undergraduate nursing and midwifery students in the last six months of training so that they could be delivered in clinical placements;

- The next stage of the COVID-19 temporary register could be to establish a specific student part to the emergency register which would be voluntary – although as we go on to show below this was not enacted and a different approach to the student deployment was subsequently followed.

The actions to operationalise the 4-point letter occurred over a seven-day period between the 20th and 27th March. On the 25th March, the NMC Emergency Register Policy was approved, supported by government emergency legislation (Coronavirus Act 2020). This enabled the NMC to launch the temporary register on the 27th March. The NMC Council agreed the conditions for the temporary registration of overseas trained nurses (nurses from outside the EU who require a period of supervision and assessment before being able to join the NMC register) on the 25th March. These nurses were invited to join the temporary register with conditions on the 6th April – the same day as the CNO's second letter, the 7-point plan, was issued.

On the 22nd March, NHS Professionals (NHSP) Rapid Response Service was launched in tandem with the Bringing Back Staff campaign. Four days later, on the 26th March, an agreement was reached with DWP to second non-patient-facing registered nurses to the NHS.

A second letter, the 7- point plan, was issued to Regional Chief Nurses and DoNs on the 6th April. This provided more detail on the various initiatives to expand the nursing workforce. The 7 points were as follows:

- It was noted that the NMC had established a temporary register, with an initial focus on encouraging those nurses who had left the register over the last three years to return to the workforce. It also suggested that at the time of the letter 6,500 returners had joined the register and completed the NHSE/I deployment survey which was distributed daily to regional workforce cells;

- It stated that the CNO had written to all registered nurses working in ALBs to ask them to return to clinical practice. The letter also states that the CNO had written to registered nurses in academia asking them to also consider going back into practice or into indirect care roles;

- It set out agreement between stakeholders for mobilising nursing students:

  - Second years and those in the first six months of their third year would be invited to opt into a revised programme model (80% of time in clinical practice and 20% in academia) paid at a Band 3 level;

  - Third year students in their final six months of study would be invited to opt into extended clinical placement, thereby voluntarily stopping the academic element of their studies for the duration of the emergency period, first in a Band 4 role (for 4-8 weeks). If the NMC extended the temporary register to them, they would be offered a Band 5 role following appropriate induction and governance;

- It was noted that the NMC would also invite those nurses who left the register between 4-5 years to join the temporary register with conditions;

- It noted that the NMC temporary register would allow overseas qualified nurses to join with conditions if they had completed all parts of their NMC registration process apart from the final clinical examination (OSCE);

- It noted that registered nurses and midwives working for the Department of Work and Pensions (DWP) would be invited to be deployed to support the NHS during the pandemic;

- It introduced NHS Professionals' (NHSP) COVID-19 rapid response service to boost support for front line services by enabling registered nurses and other healthcare professionals to further bolster the workforce as temporary staff.

2.4 Beyond the 7-point plan letter

At the same time as the CNO issued her 7-point letter, NHSE/I was issuing a significant amount of other guidance. For example, NHSE/I and the DHSC wrote to the service about the demand for registered nurses in the social care sector on the 15th of April (COVID-19: Our Action Plan for Adult Social Care), the impact of COVID-19 on the safety of staff on the 13th of April (COVID-19: Deploying our people safely Version 1.1), and to highlight the needs of staff from BAME communities on the 30th of April (COVID-19: Deploying our people safely Version 1.2).

The CNO told us in her interview that she considered some of the actions covered in these other guidance documents to be part of her overall workforce strategy: for instance that the buying of the entire independent sector capacity, including its staff, expanded the workforce available to the NHS and that the change in critical care ratios expanded the ability to use current staff to care for more patients. The connections between the overall nursing workforce strategy and these other actions set out in guidance outside of the 7-point plan, have not been made by any other individual or group we have engaged with within our study.

3. Operationalisation & Communication of the 7-point plan

The Review Group recognises the challenging circumstances and pace at which the plan was issued. Whilst acknowledging this, our terms of reference require us to establish if the plan was the right plan and whether it included adequate operational detail to ensure its implementation was as effective as possible. We have also considered if the plan met the needs of providers and systems, and how operational issues of the plan were considered including risk and accountability. Our work relates to England only and we consider the English workforce in this and the next chapter.

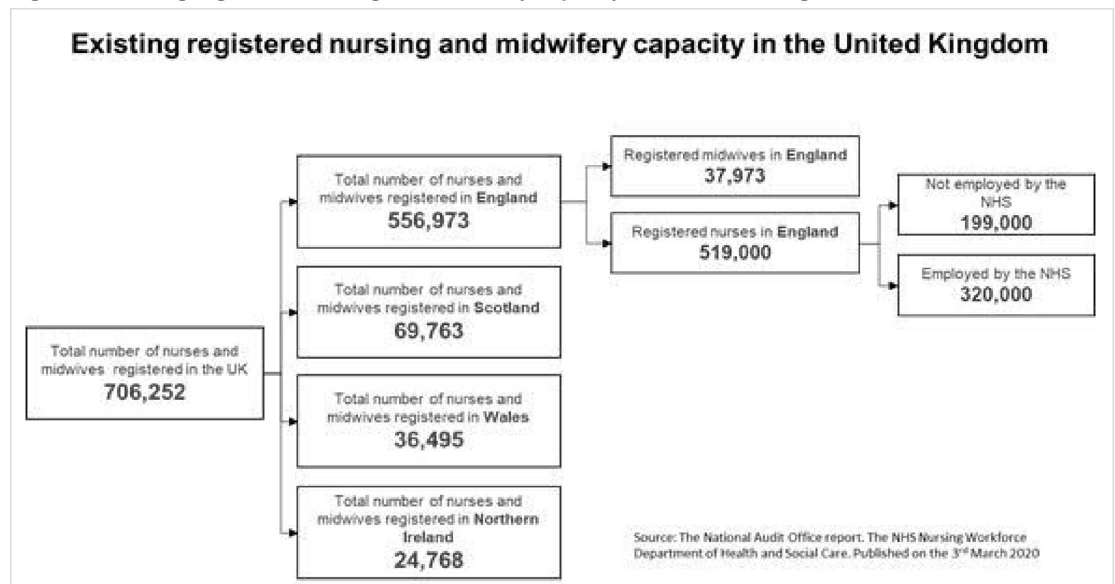
3.1 Increasing the nursing and midwifery workforce capacity

Currently registered nurses not in the NHS

Figure 1 demonstrates that, in England, there were 199,000 registered nurses not employed by the NHS. We have heard mixed views about whether this group was approached to support the NHS response to the pandemic. While some interviewed felt that this group was not considered at all, others suggested that a large proportion of these individuals were already employed in patient facing roles, for example in social care and the independent sector and therefore they were not felt to be viable options for expanding the workforce within the NHS. By contrast, the CNO said to us that parts of this group were deployed to support the NHS – notably registered nurses employed by the independent sector who helped to support cancer and urgent elective work. However, these registered nurses have not been included in any workforce deployment data that we have seen, and no reference was made in either the 4- or 7-point plan letter to mobilise this group beyond the reference to registered nurses in academia.

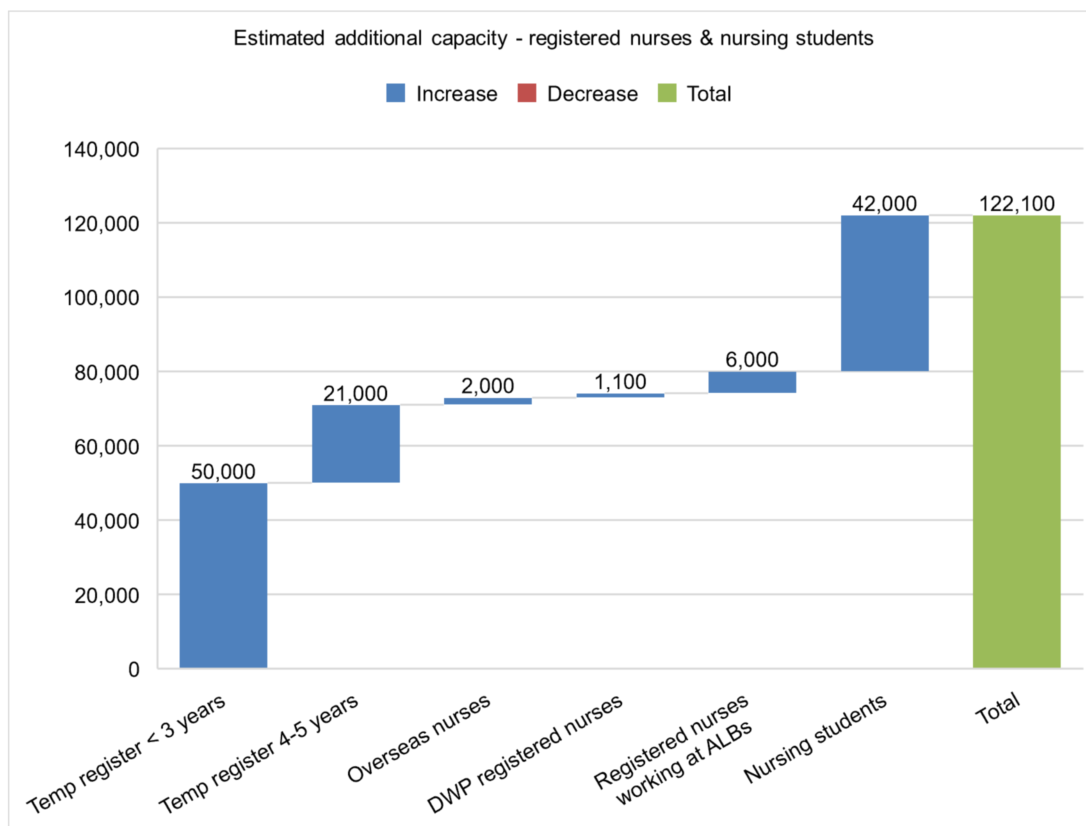
As very limited data is held by the NMC on nurses on the register, the Review Group has not been able to obtain an analysis of the types of role being performed by the 199,000, for example, numbers in academia or in consulting roles, in addition to those in social care and the independent sector. Without this data, it is difficult to assess whether greater use could have been made of registered nurses working outside of the NHS.

Figure 1: Existing registered nursing and midwifery capacity in the United Kingdom



The key actions in the 7-point plan for increasing the availability of nursing staff were the temporary register and the deployment of nursing students on extended clinical placements. In total the plan identified a potential pool of 80,000 registered nurses (through nurses on the permanent register but working in DWP or ALBs and introduction of the temporary registers) and 42,000 year 2 and 3 nursing students. Figure 2 shows this in more detail. Later in this report we show that the realised yield was significantly less, although it is unclear what a reasonable target may have been given the scale of the pandemic and the perceived impact on the NHS.

Figure 2: Estimated additional capacity – registered nurses & nursing students



3.2 Inclusion of midwifery in the 7-point plan

The inclusion of midwifery in the plan generated divergent views. To some, it was a distraction and the focus was really on the provision of nursing in acute critical care. To others, the ability to mobilise additional midwives to support staff sickness and absence was important.

While the 7-point plan was to cover both the nursing and midwifery workforce a number of approaches in the plan were not appropriate for the midwifery workforce, specifically the NMC temporary register and the use of overseas nurses, details of which are explored further in subsequent sections of the report.

Overall, the impact of the plan on midwifery was marginal, with the Chief Midwifery Officer commenting that the use of midwifery students was the main benefit achieved. Certainly, our focus groups did not suggest that midwifery shortages were an acute problem during the pandemic.

3.3 The recognition of specific nursing skills required in the pandemic

In the initial stages of the pandemic, the emphasis was on increasing the total healthcare workforce as much as possible. The 7-point plan focused on expanding total nursing numbers, with no mention of prioritising source or skill sets. A number of our interviewees with national roles suggested that discussions focussed on redeploying registered nurses already working in the NHS, mobilising temporary registrants and students in that order of priority. We have not seen a risk assessment of the overall plan which demonstrates that this prioritised approach was indeed used to inform recruitment or deployment.

Stakeholders indicated there was a lack of focus on the specific nursing skillsets. Despite the demand side modelling demonstrating the need for critical care skills in the early stages of the pandemic, the plan did not target mobilising registered nurses with these skills first. Nor did it prioritise rehabilitation skills as the recovery needs of some patients become clear. A plan based on recruiting staff by identifying skills needed to deliver the anticipated care mode could have enabled prioritisation of different cohorts of staff to return and a faster deployment to the frontline.

Those joining the temporary register were invited to complete a survey, led first by the CNO office and later by Capita on behalf of the BBS campaign. Whilst not all returners completed the surveys, we were told that it failed to adequately capture the pre-existing skills of those who did complete it. This inhibited the fast-tracking of individuals with high priority skills through pre-employment checks. The lack of information caused a duplication of effort by necessitating further conversations at local level around skills.

Overall, our fieldwork indicated that the seven initiatives identified to increase supply were appropriate to increase the total capacity of registered nurse and midwifery numbers. However, the system for enacting the plan did not indicate the relative importance of each of the seven initiatives and did not always work smoothly.

3.4 Risk assessments

3.4.1 Overall risk assessment of the 7-point plan

No evidence of a formal risk assessment has been shared with the Review Group. Our focus groups with Regional Chief Nurses and leaders from a range of providers indicated there was not a single national approach to assessing risk. When questioned about local risk assessments, some providers indicated that they had performed Quality Impact Assessments when there were changes in the way services were delivered. However, QIA lack the risk scoring matrix used routinely across NHS organisations and would not automatically pull through onto an organisation's risk register or be necessarily reported through to the Board.

3.4.2 Risk assessment of the temporary register

The NMC Council agreed an Eligibility Group Decision Table (the version we received was dated 9th June) to identify which groups of potential returners could be included on the Temporary Register and any conditions of practice they would require. People who previously had fitness to practice concerns raised about them were excluded from the invitation to join the temporary register. In addition, those over 70 were not proactively invited to join the register (although they were still eligible and could apply, with some choosing to do so). No conditions of practice were applied to those who had left the register in the last three years. Some conditions were placed on the 4-5 years cohort because of the time since they last practised. The Overseas trained nurse cohort were offered conditional registration, having never been on the permanent register.

An equality impact assessment was maintained by the NMC throughout the pandemic. The NMC established a coronavirus hub on their website which includes information for employers and the expectations of support to be given to staff on the temporary register.

NHSE/I undertook a retrospective risk assessment of the Bring Back Staff campaign outlining key decisions which were taken and their impact on the achievement of the programme's objective. However, the document provided to the review group is not dated and no author is indicated. The assessment outlines the benefits which the programme aimed to achieve and describes how the perceived risks and issues associated with the programme were managed.

3.4.3 Risk assessment for the student group

An assessment of the risk of deploying nursing students was completed by HEE and has been shared with the Review Group but is not dated or authored. The assessment concluded that nursing students could be deployed into paid extended clinical placements and that third-year students could be recommended for the NMC temporary register, if a subsection for nursing students was opened. Options for mitigating risks, such as revoking students' supernumerary status, pausing first year students' placements, are considered but no recommendation was made.

The Heads of Nursing Schools that we spoke to commented that they undertook local risk assessments for individual students before they were deployed into practice. They noted there was no national framework for this and there was a concern that each HEI may have performed slightly different risk assessments, even where they were sending students to the same provider organisation alongside a further local assessment that could have been conducted by the receiving provider too. This was of concern as HEE enabled students to be placed at a distance from their HEIs and placed in clinical areas not known to their HEI.

3.4.4 Risk assessment for overseas nurses

The NMC completed their assessment of the risks of an overseas nurses' subsection of the temporary register on 27th March 2020.

Overall, the risk assessments we have seen have not followed a national framework and, in some cases, lack authors and/ or dates or version control. It has been unclear how they have been approved. Those risk assessments that we have seen are have not been widely known about and it is unclear how they have influenced decision making or operational delivery.

3.5 Nature of the communications regarding the Plan

The CNO's letter describes 7 points for action. It has been described to us by the CNO office as the 7-point plan and is acknowledged as such in our Terms of Reference approved by NIRB. Many interviewees, and focus groups said that they did not view the letter issued by the CNO on 6 April as a plan. Instead they described it as a strategic intent or a summary of initiatives and they expected operational detail to follow.

It is unclear how the operational detail would be agreed. Some participants in our focus groups, especially those from CCGs and Integrated Care Systems, commented that their roles in relation to the letter were unclear, and it was not apparent who needed to do what. Local leadership began to redeploy their existing workforce and took local actions but were unsure how this related to national plans.

The Review Group discussed the fieldwork finding and concluded that there was a breakdown in the system, leading to a lack of operational detail, allocation of roles and responsibilities, including in relation to governance and monitoring. There was some disagreement about whether national guidance on operationalising the plan was required and how much was the responsibility of regional and provider DoNs. Some group members felt that senior nurse leaders are sufficiently skilled and experienced to translate the plan into operational delivery. However, the ambiguity meant that there were both overlaps and gaps, and accountability arrangements could have been clearer.

Through our fieldwork, we heard that a large volume of communication was received by local leaders, and at times with potentially conflicting messages. We heard that communications being sent directly to HEIs from HEE were slightly different from those being sent to providers by NHSE/I. This meant that there were nuances in the messages and these were interpreted in different ways causing confusion.

We also heard that some of the 11 provider DoNs and regional workforce leads who took part in our focus groups did not recall the 7-point plan letter at all which they felt was likely due to the vast number of communications received during this time. Others were not aware of the 7-point plan letter but did recognise the initiatives within it. Regional workforce leads commented that they often received communication about nursing students at the same time as HEIs and providers meaning that they found it challenging to respond to queries with confidence.

We have heard divergent views on the communication regarding the mobilisation of students onto clinical placements. Some interviewees and focus groups have said that the coordination of communications between HEE, Council of Deans and individuals HEIs was challenging and that the mismatch in timing sometimes led to confusion. Others have said that this was not a major issue and that the lack of student issues escalated to national union representatives to help resolve indicates that where there was uncertainty it was resolved at local level. Student representatives and students themselves have indicated to us that communication was good, with the CNO, HEE Chief Nurse and HEIs giving comprehensive information.

In contrast to the large volumes of communication to students and local leaders and managers, there has been relatively little communication with temporary registrants or with registered nurses working outside of the NHS. There was little by way of advertising to these groups to bring more staff into the frontline, to explain delays to them in their pre-employment check when delays became clear, or to explain why they had not been employed if that was the case. We heard of some trusts that used social media including twitter posts asking for nursing staff to contact them directly if they were interested in working on the front line. In chapter 4 we describe the lack of focus on ongoing engagement with temporary registrants which, coupled with the above, means we believe that their willingness to support the response to a second wave may be diminishing.

3.5.1 Relevance and quality of communication

We heard that the fact that the plan was not disseminated to all relevant individuals or to staff themselves may have negatively impacted and/or delayed the scale of the response. The Chief Nurse at NHS Professionals told us they were not included in the early conversations which delayed their response. The CNO webinars and local briefings were reported to be a helpful way to provide some greater clarity; however, the invitations were not broad enough.

Whilst both the 4 point and 7-point plan letters were shared through the Incident Coordination Centre, we found that subsequent communications did not necessarily go through this route. For example, the Bring Back Staff Campaign Situation Report requirements were not distributed through this route. Use of the ICC did not guarantee recipients read the letter and there were some reports of regional variation in the communication of the 7-point plan. Some of the 27 DoNs from our two provider focus groups indicated they had not received the letter from the Chief Nurse (though they recognised many of the individual points) while others reported having had clear communications from their Regional Chief Nurses throughout the process. Some gave examples of where Regional teams had directly shared the national and central communication with them verbatim, whilst others said regional teams had shared revised communications or developed new ones based on the specific region or providers circumstances. There was also variation in how quickly regions distributed information to local organisations.

3.5.2 Integration of CPO and CNO office communications

Regional workforce hubs played a central liaison and coordination role. Workforce leads were also the Senior Responsible Officers for the regional workforce cells. However, our fieldwork with the CPO team, the regional workforce leads focus groups and HEE leads indicated that many had not received the 7-point plan.

Recommendations

- Risk assessments should follow a national framework, with version control, date of agreement and author details.
- Greater focus should be placed on clarifying accountability for specific actions.
- All communications should routinely be routed through the Incident Coordination Centre, with consistent and wider distribution lists reflecting the nursing and people responsibilities in operationalising a workforce plan.
- Minimum data sets monitoring the impact of actions should be agreed and communicated through the ICC. Where data is required from other ALBs or stakeholders this should be clearly agreed, documented and provided through a single route.
- We recommend that the CNO office work with the NMC to complete further analysis of the skills and availability of registered nurses on the permanent register but not employed by the NHS so that informed decisions can be taken as to whether this cohort should be specifically targeted (and if so, how) in future waves.
- Separate assessments for increased midwifery capacity (for example, to cover illness and those shielding) to be performed in future and discrete actions to be developed.

4. Operational Delivery

4.1 General feedback on the operationalisation of the 7-point plan

The Review Group noted that the CNO letter did not contain operational delivery detail. This view was reinforced during interviews and focus groups with a number of regional and provider respondents saying that they did not recognise the letter as a plan and that they had anticipated receiving further operational detail on how the plan would be progressed and who would be accountable for each element of delivery.

Operational delivery plans were cascaded from regions to localities. However, by the time the 7-point letter was released many of the circa 35 Directors of Nursing who joined our focus groups had already instigated actions required to support care delivery and the status of the CNO letter was unclear.

Different points in the plan were led by different parts of the system. The plan for deploying those on the temporary register and those returning to the NHS relied on close working between regional chief nurses and regional workforce leads. We were told that local teams felt as if they needed to 'stitch back together' what, at times, felt like a disjointed approach coming from the CNO and CPO national teams. The 7-point plan letter was not copied to regional workforce leads and the responsibility for communicating it appeared to lie with regional chief nurses. Many of the regional workforce leads we spoke with had not seen the 7-point plan until our focus group discussion, suggesting this process did not work well. We comment further on the CNO/CPO interface later in the section on temporary registrants. We have heard different views as to whether greater direction should have been provided at national level or whether greater local autonomy would have been beneficial. There was a point of view that a locally owned process would have sought only to fill the immediate need for staff in each geography, not to build up the biggest possible deployment-ready pool nationally. However, the overwhelming view from the 38 provider and system DoNs we interviewed has been that a more locally managed process would have both increased the number of temporary registrants brought into employment and provided a better experience focussed on a better understanding of their individual skills and the contribution they were happy to make. It is also clear that different approaches were taken in different areas with variation in onboarding and deployment of temporary registrants.

The developing understanding of the workforce needs led to frequent updates. These were disseminated from central sources (for example, the emerging updates on the risk related to BAME staff) to regional teams. Local organisations were responsible for implementing these, but we found little evidence of best practice being shared, leading to unintentional variation. The review group heard that plans remained hospital-centric even after the peak of admissions began to subside and workload pressures emerged in community and mental health providers.

While the Review Group recognises the speed at which the plan had to be designed and implemented meant that processes were necessarily imperfect, we observed that there was no pre-existing workforce mobilisation plan in the national pandemic strategy. Whilst the NHS was able to leverage some of the work related to EU Exit (including an Emergency Workforce Plan that we understand was previously approved by the DHSC) there was no specific plan in place that considered issues such as the impact of shielding or of raised sickness rate on the workforce or the specific skills likely to be required pandemic. We have heard from our fieldwork that more time spent involving more of those who would lead the operational response would have helped design clearer processes and accountabilities, leading to a faster and enhanced response.

Recommendations:

- NHS England should consider the development of a specific nursing workforce mobilisation plan as part of its overall Pandemic Plan. This should be developed jointly

by the CPO and CNO teams with frontline engagement, including with staff who joined the temporary register.

- Future plans should have a greater emphasis on identifying specific skills required at different stages of a pandemic and consider how this might modify the call for additional staff. This includes a recommendation for greater emphasis on all sectors of the health system (e.g. mental health, community services)

- Future workforce plans should be underpinned by risk assessments which address the impact on existing staff, returners and patients and should adhere to national pandemic risk assessment guidelines. The risk assessment should inform the prioritisation of different elements of the plan.

- Plans should include clear roles and responsibilities for implementation and communication, considering the role played by stakeholders at national, regional and local levels. This should include accountability for both delivering the plan and monitoring its efficacy.

- National minimum data sets on the recruitment and deployment of additional staff in a pandemic should be agreed.

4.2 Redeployment of registered nurses on the permanent register

Redeployment of registered nurses on the permanent register within NHS provider organisations, together with those working in ALBs and in the independent and third sector was viewed as an integral component of the national response to increasing nursing capacity in order to meet the anticipated demand. We heard that efforts focussed on four processes:

- Internal redeployment of nursing staff not working in clinical care within NHS organisations;

- Registered nurses employed by Arms Length Bodies (ALBs) for example, CQC or NHSE);

- Registered nurses employed by the Department of Work and Pensions (DWP);

- Registered nurses deployed through NHS Professionals.

There was limited attention given to mobilising registered nurses outside of these groups, such as those in academia or self-employed. We have been told that this was because it was considered that these registered nurses were often working clinically and supporting sectors such as nursing homes and primary care, although no evidence was provided to support this assertion. Given the large number of nurses on the permanent register not employed in the NHS, further understanding of their employment and availability would be helpful.

4.2.1 Internal redeployment

In addition to the capacity generated as a result of the levers identified through the 7-point plan, a large component of the NHS response was the redeployment of registered nurses within organisations and health systems from one unit to another to meet local needs. We heard from regional and local leaders that redeploying staff within their own organisations was the most effective way of increasing capacity in acute and critical care settings. They noted that the hard shut down of elective and non-urgent services, coupled with the more unexpected reduction in the number of patients accessing urgent care services, meant that they could redeploy their own staff to support areas providing COVID-19 care. Our survey of 11 Directors of Nursing corroborated this view. They reported that they moved up to a quarter of their staff, but this accounted for over 75% of the increase in registered nurse staffing in COVID-19 areas. They noted that this meant a significant number of staff were working in areas outside their usual clinical practice placing strain on the deployed staff and on those staff, who had to supervise them. The Review Group discussed whether this experience may

lead over time to increased staff attrition. It is unclear what preparation, training or support internally redeployed staff were offered or how the experience impacted on staff satisfaction and to what extent internal redeployment impacted staff sickness absence.

Providers also commented that local efforts to increase front line capacity through deploying their existing staff will not be visible from current data sets. The Review Group noted that it is unlikely that there will be a hard stop of elective and non-urgent care in the same way for any future waves, meaning providers will not be able to place as much reliance on redeploying existing staff. This then represents a risk given that we heard this was the most widely used approach to staffing COVID-19 areas in wave 1.

The 27 DoNs in our two provider focus groups told us that at local level they were also able to bring registered nurses who were on the permanent register but not in clinical practice back to the frontline. Providers gave examples of where they had entered non-clinical secondments and of CCG nursing staff being successfully mobilised. Local relationships brokered across systems made these changes relatively easy to achieve. We have not received data to understand the scale of this expansion but given the relatively small size of CCGs it will have given only a modest benefit.

We heard examples of registered nurses directly approaching their local health care providers to offer support. This was reported as being useful as it allowed more tailored conversations about what people felt comfortable doing. A small number of DoNs in our focus groups also commented that that perhaps HCAs could have been considered as part of the plan, for example, encouraging formerly registered nurses who had left the permanent register, and did not feel comfortable joining the temporary register, to consider taking on HCA roles where a number of their skills would have still been utilised, although members of our Review group urged caution as there would be risks associated with this approach.

Whilst these local efforts were reported as being successful in mobilising staff to acute settings, particularly in the early stages of the pandemic, stakeholders have warned that in some cases this meant pressure being put on other parts of the system and that there may have been unintended consequences, for example reduced staffing on general medical wards.

4.2.2 Arm's Length Bodies

We have not seen data showing how many registered nurses returned to clinical practice from ALBs, but our provider focus groups did not identify this as a key route to bring in more staff.

4.2.3 Department of Work and Pensions

Redeploying registered nurses working in the DWP was another initiative identified in the 7-point plan. This was an inter-departmental agreement at the government level. Staff within DWP not working in clinical roles were invited to register their interest through a survey which was passed on to the regional workforce cells through the Bring Back staff campaign.

Overall 1,009 DWP registered nurses were identified as being eligible to support during the pandemic and 829 completed the survey and were contacted by the region representing a strong uptake. However, the data provided to the review group did not provide further details on deployment or employment figures. Whilst very helpful, this represented a small percentage of the demand for additional nursing staff.

4.2.4 NHS Professionals

NHSP set up the Rapid Response Service to accelerate the employment of registered nurses (both those on the permanent and temporary NMC registers). We have heard mixed views about the involvement of NHSP and the role it played. We have been told that a larger role in undertaking pre-employment checks and deploying staff was considered for NHSP, but it was felt to have a mixed reputation within the NHS. We understand that the risks of the

accelerated service were discussed between the CNO team and NHSP leadership, although we have not seen a risk assessment.

Our fieldwork with individuals who offered their services through the NHSP Rapid Response Service suggested the process to register with the Rapid Response Service to be quick and simple, providing an easy route into being deployed in the frontline. The Chief Nurse for NHSP spoke to us about having a clear focus on understanding what people could offer, including when and where they could work. She also spoke about the need for Trusts to understand the different needs of people returning to practice, with deployment to the same wards and teams helping with staff retention, as well as preventing cross infection.

Returners to the NHS employed through NHSP stated that their colleagues on wards were frequently not aware they were part of the Rapid Response Service and therefore the expectation was that they would be able to hold a normal caseload of patients without needing additional support. Some returners felt it would have been beneficial for staff on the ward to be aware that they were being deployed through the Rapid Response Service and that they may initially need some additional support or guidance. In some cases, returners ended their involvement because they had felt overwhelmed by the demands placed on them from the wards and they did not feel confident they could perform the duties being asked of them. On the other hand, some of the nurses within our NHSP focus group are continuing to work shifts through NHSP and feel they would like to maintain this on a regular basis, although it is recognised this is the view of a small sample and these views may not represent all staff. These staff spoke about the reinvigorated connection they feel to the nursing profession and to patients.

There was variation in the training provided for temporary registrants returning through the Rapid Response Service. Some respondents said they were required to complete a one day or half day training ahead of returning to clinical work at an NHS Trust. Training included an overview of trust policies, manual handling, use of clinical equipment such as ventilators and training on use of PPE. Others stated they had not been asked to complete any additional training ahead of being employed on a ward. All returners we spoke to recognised that additional training or signposting to relevant training materials would have beneficial in refreshing their skills and building their confidence.

Data provided by NHS Professionals demonstrates a significant contribution to increasing the nursing workforce available to work, although this was not translated to shifts worked. We do not have data on why this conversion did not occur. Staff were more likely to be deployed if they had a pre-existing link with an individual Trust.

1. *Pre-matched and approved by an NHS Trust: typically, these were individuals who had left Trust employment but were keen to come back and support*

Table 1: Work ready and deployed staff, by profession

Role	Work ready (individuals)	Deployed (individuals)
General registered nurses	2,141	1,436
A&E registered nurses	464	327
ICU registered nurses	439	294
Midwives	426	295
HCAs (acute)	2,821	1,982
HCAs (RBH)	862	532
Total	**7,153**	**4,866**

From these 4,866 individuals, NHS Professionals was able to book 134,458 shifts to support with the response.

2. *Cold expression of interest: registered nurses and midwives who were not pre-approved by an NHS Trust and required a more intensive screening and matching process*

In this group, there were 9,236 expressions of interest, 4,224 went through the screening and were deemed to be work ready, and 3,630 were matched to an NHS Trust. The regional split is shown below in Table 2.

Table 2: Work ready and match individuals, by region

Region	Total Work Ready	Matched to NHS Trust
East of England	471	418
London	567	502
Midlands	614	508
North East & Yorkshire	680	593
North West	772	688
South East	767	659
South West	335	256
Other	18	6
Total	**4,224**	**3,630**

Of the 4,224 deemed 'Work Ready' 3,001 represented net new staff that did not hold an NHS substantive post and were not known to an NHS Trust. NHSP booked 18,196 shifts for this group. They may have been previously working in the independent sector or represent temporary registrants volunteering to work for Trusts in which they were not known.

In addition to the numbers deployed to clinical areas, NHS Professionals recruited and completed pre work checks on 9,238 and deployed 8,652 to the Test & Trace program. They also recruited 1007 for the Nightingale hospitals.

Table 3: Staff deployed to and employed by the Nightingale site across England

Region	Workers deployed	Workers employed
Nightingale London	616	32
Nightingale North West	266	139
Nightingale Yorkshire	125	0
Total	**1,007**	**171**

The 7-point plan to increase the number of registered nurses available did not yield the additional nurses that some in our fieldwork expected. Most providers reported that they increased their capacity through deploying existing staff. The Review Group concluded that future waves of demand are unlikely to be able to access this source of staff as other services are unlikely to be stopped and instead future plans should seek to increase the overall numbers of registered nurses available to the NHS. NHSP was able to provide additional registered nurses through its Rapid Response Service and consideration should be given to the increased role that NHSP might be able to play in supporting providers.

Recommendations:

- National guidance on the support required by registered nurses deployed through the Rapid Response Service should be provided.

4.3 Temporary register

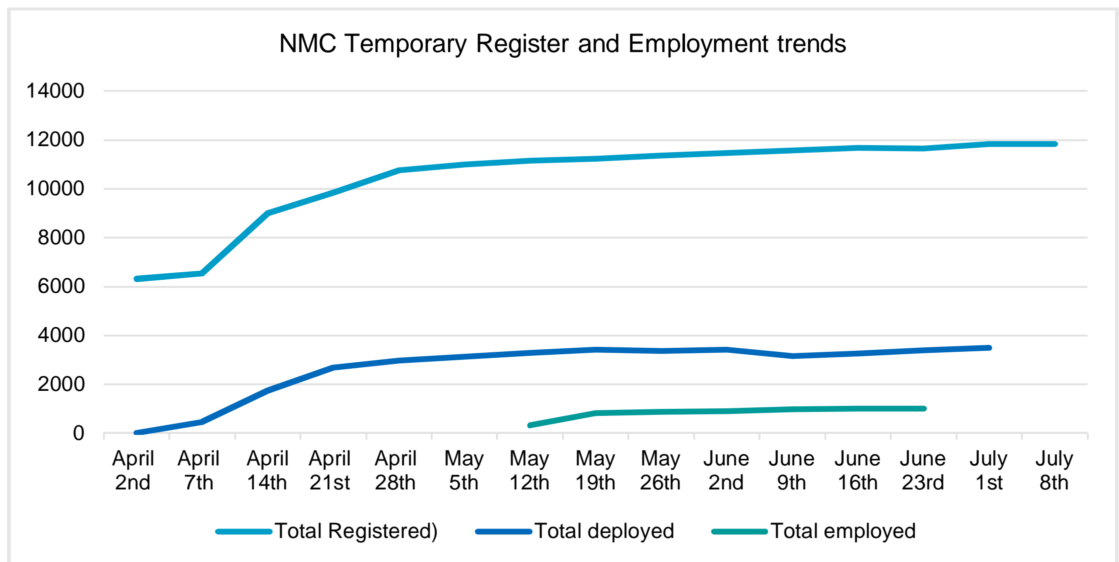
The likelihood that redeployment will be harder in future pandemic waves places greater emphasis on recruiting to the temporary register. The temporary register was opened initially to nurses who had left the register in the last 0-3 years, then to nurses who had left the register in the 4-5 years, and to certain overseas nurses who were already in the process of joining the NMC register.

4.3.1 Returners: 0-3 years and 4-5 years

We heard that the opening of the temporary register by the NMC had been well received by providers. The data indicates that 73,000 people would be eligible across the UK, although no target for recruitment was set. Initial yields were less than many people expected with 14,251 joining the register of whom 11,834 had addresses England. We heard of difficulties in mobilising these temporary registrants and found that 29% of these (3,490) were considered work ready and their details given to providers through the BBS process (excluding those referred to 111). Of the work ready temporary registrants notified to providers 9% (1,007) entered employment (Figure 3). We are unclear how many temporary registrants entered employment outside the BBS process, however the number of nurses employed from the temporary register through BBS represented only 7% of the potential. The Review Group concluded that attention should be paid to research how the temporary register is viewed by potential registrants and what further actions can be taken to increase the supply of temporary registrants to support the NHS during the pandemic.

It has been difficult to understand how many staff on the temporary register were employed in individual providers, and what roles they undertook. Although we have been told by regional leaders that there was natural attrition at each stage, of which some we believe is as a result of changes to personal situations and preferences to support the COVID-19 response, we have not heard from temporary registrants themselves. It is unclear the extent to which the recruitment processes contributed to this loss of potential staff.

Figure 3: NMC temporary register and employment trends



Deployed means work ready and details shared with employers, employed means contracted and worked

Once individuals had joined the temporary register held by the NMC, registrants were asked to undertake a survey administered initially by the central CNO team and then subsequently by Capita. Pre-employment checks were undertaken at this stage. We heard that the process was perceived to be slow and clunky. Data provided by the Bring Back Staff campaign showed that it took 26.5 days on average from the time Capita received the survey to details being sent to an NHS provider. Some temporary registrants told us they did not complete the survey and instead contacted Trusts in their local area directly. Regional and local teams told us that the data from the survey did not provide sufficient information on the skills and experience of the temporary registrants, nor the type of work and shifts they could offer. This led to further delays as local teams undertook further screening.

We understand from the CPO team that Capita were brought in in March when it became clear that the NHSE/I team would be overwhelmed by the numbers of temporary registrants from all professional bodies coming through the BBS route –not just registered nurses, but also other professional groups. We also heard in some interviews that the volume of work had been overwhelming and that Capita had needed to mobilise processes at pace, meaning there was less time for detailed information. Nevertheless, the central process introduced delays for providers and meant that many returners got stuck in limbo during the height of the pandemic.

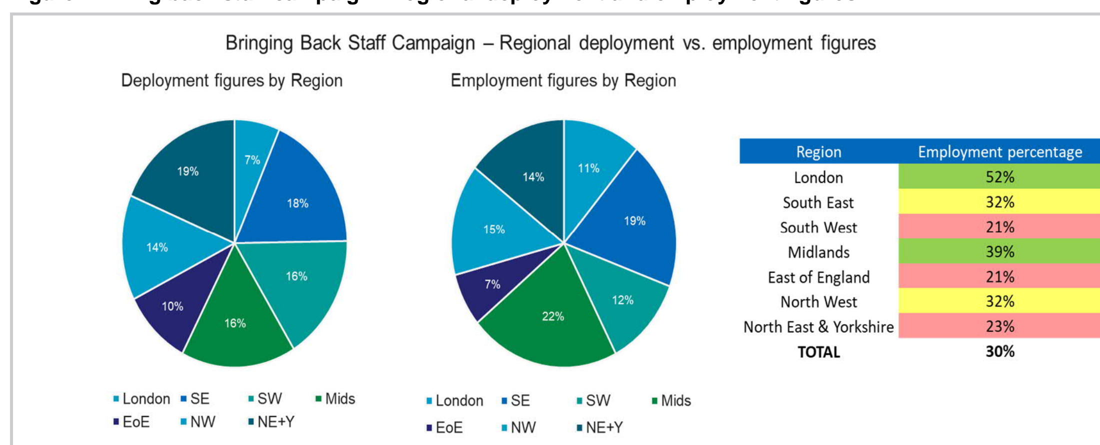
There are indications from our national and regional interviews that the CPO and CNO teams were working hard but there were missed opportunities for alignment. Provider and regional representatives told us that CPO and CNO teams communicated separately, and sometimes outside the Incident Control Centre route. Regional teams talked about how they had to piece together an approach from a sometimes inconsistent national steer.

Focus groups with regional teams indicated that after receiving information from the BBS team, they directly approached temporary registrants, although it was challenging to communicate with all registrants in a consistent manner. meaning temporary registrants had little personal communication. It appears that the system supporting temporary registrants back into practice was under resourced at both national and regional level. As with other points on the plan, there was little stratification of the call for temporary registrants meaning that the national and local teams were not able to prioritise those temporary registrants with the skills and experience most in need at any given time.

Our fieldwork found that providers and local system leaders believe that the process for deploying staff from the temporary register would have been more effective if there had been more local control and that challenges with the centrally run process reflected poorly on the profession and damaged their local credibility. A local process would have provided the opportunity to respond to local needs across services, care settings and they could have utilised their existing recruitment teams to complete pre-employment. We are aware that there was variation in how Trusts inducted, onboarded and rostered returners and we heard that this is likely to have influenced returners views about whether they will support the NHS in future waves of the pandemic.

The local attention to the individual experience of temporary registrants may also explain some of the variation observed regionally in temporary registrants' employment in practice (see Figure 4). The London regional hub received only 7% of the total registered nurses deployed via the BBS campaign, but accounted for 11% of all registered nurses employed in frontline positions with 52% in clinical positions. It has been suggested that the higher conversion may have been due to the higher rate of demand in London in comparison to other regions, however further exploration is needed.

Figure 4: Bring back staff campaign – regional deployment and employment figures



Region	Employment percentage
London	52%
South East	32%
South West	21%
Midlands	39%
East of England	21%
North West	32%
North East & Yorkshire	23%
TOTAL	**30%**

Some national stakeholders viewed that the low use of temporary registrants was due to changing demand. However, our acute, community and system focus groups disputed this and indicated that had they been provided with more information they would have employed more temporary registrants. Some commented that consideration should be given to how this group could be utilised in the future to cover staff taking leave, sickness, and reopening services. The Review Group noted, however, that temporary registrants' motivations have not been explored and assumptions about what they would be prepared to offer should to tested with them.

DoNs we interviewed talked about the focus on increasing the number of staff, without due regard for either skills or availability. They were encouraged to take temporary registrants into non-patient facing or support roles, but these were often being undertaken by existing staff who were shielding. There was a view that BBS did not have a good understanding of the complexity of registered nurse staffing and the number of factors that need to be taken into consideration. We have not spoken to temporary registrants to seek their opinions on this, and we suggest that their views are sought.

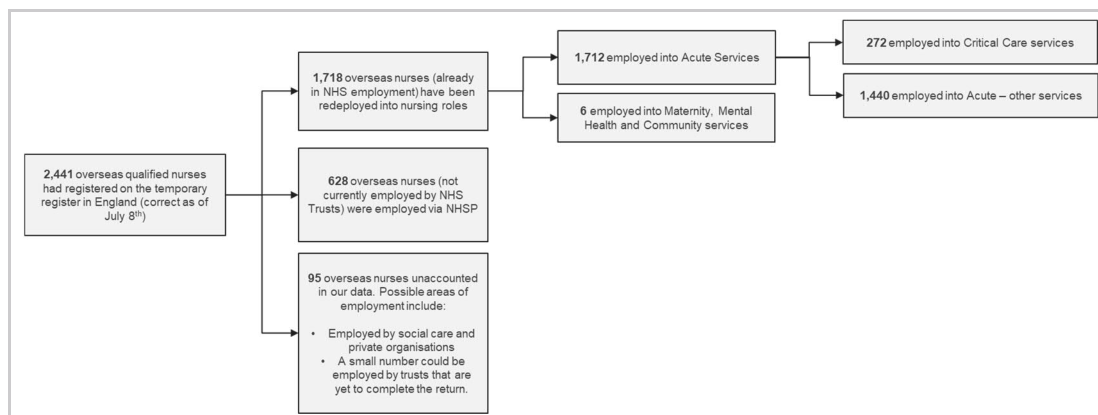
NHSP has had a limited role to date in supporting the BBS deployment of temporary registrants even though they had capacity to support Trusts with employment contracts and payroll. Regional HR Directors commented that local leaders are now responsible for engaging with temporary registrants, including those who have not yet been deployed. We understand from the CPO team that nearly all returners who joined the temporary register have now finished their pre employment checks and are ready for deployment, although it is unknown how many of these are still prepared to be employed. Local leaders have not indicated to us that they understand they are now accountable for talking to returners and maintaining contact so that that they could be rapidly deployed in subsequent waves. We understand that there is a plan to undertake 'career conversations' with around 2500 returners who are ready for deployment but have not yet been employed to try and attract half of this number to support the NHS going into winter. We did not explore whether returners who responded to be part of the national effort during the pandemic have indicated that they wish to work in the NHS on an ongoing basis, however we are aware of a survey undertaken by the NMC in July which indicated that some returners were, at that stage, likely to re-join the permanent register.

4.3.2 Overseas trained nurses

The number of overseas trained nurses joining the temporary register (1718) was a significant proportion of those eligible. However, it is important to note that many of this group were already employed within the NHS and had completed all parts of their NMC registration process except the final clinical examination (OSCE) courses meaning that although their status had changed, there was very little increase in headcount.

In contrast, the 628 and 95 overseas nurses highlighted in the diagram below as not being previously employed by the NHS (Figure 5) represent net increased capacity. We have not seen data showing where these nurses were working before they joined the temporary register and we cannot be sure if they were drawn from other critical sectors such as care homes.

Figure 5: Deployed overseas trained nurses



Most of the overseas nurses we spoke to said that the NMC invitation to join the temporary register was followed up by their local international recruitment teams. They agreed the online application to get onto the temporary register was quick (taking 1-3 days on average), clear and straightforward. Overseas trained nurses indicated that sufficient communication and information was provided on the application process and they felt well supported by their local teams.

Our overseas trained nurse focus group reported that comprehensive and accessible training was given by their providers, and any concerns regarding their liability were addressed by the restrictions on practice put in place by each provider. Overseas trained nurses we spoke to felt they received appropriate supervision and pastoral support throughout the process and described it to be a valuable learning experience which gave them the opportunity to improve their confidence and skills ahead of their OSCEs and they felt a strong sense of pride be work on the frontline during the pandemic. They said it was made clear to them they would still be required to complete their OSCEs and follow the usual process to be eligible to join the permanent register, despite being employed on the temporary register during COVID-19.

4.4 Communication around the temporary register

The numbers of returners joining the temporary register was significantly lower than the number eligible. Understanding the motivation of returners, how they can contribute and for how long are fundamental questions the CNO will wish to understand if the temporary register is to provide support to the NHS going forward. We are aware that the communications from the NHS to returners has been from the BBS team and been generic, covering multiple professional groups. The CNO may wish to consider how she establishes a clearer professional line of communication to returners. Understanding the experience of returners at every stage will shape the communication required. Understanding why people did not come forward, how they felt if they have not been deployed or employed to date, and the experience of those who have returned to practice, whether through BBS or direct to Trusts will help inform future communication strategies to engage, motivate and retain returning staff members.

Our field work around nursing students shows that stakeholders all recognised the change in communication about the approach through which nursing students would be employed. Initially, the 7-point plan stated 3rd year nursing students in their final six months would be placed on the temporary register if the NMC chose to open it. However, they decided not to open the temporary register to nursing students on May 7th. The interviewees and focus group attended commented that the rationale for this was unclear and took a long time to disseminate through to providers and trusts. See further commentary on nursing students in section 4.6.1.

Ongoing communication with temporary registrants will be key to assessing their appetite to continue to provide temporary support. In some interviews we have heard that the focus should be on converting returners to substantive staff, others have reflected that leavers left the register for a reason so understanding their motivation and being flexible to their needs is key if they are to continue to offer support.

In future, this stream of the 7-point plan is likely to be the key to expanding the workforce to support increased demands. Getting it working better at all levels; numbers onto the registers, faster pre-employment checks, great numbers in employment, is key. Paramount will be continuing to engage and retain the returners currently on the temporary register. It is not clear to us who whose job it is to engage with returners. There is a danger that without this the NHS may lose the goodwill of current returners and fail to engage others to return.

Recommendations:

- The CNO should:

    1. Work with stakeholders to understand why the numbers attracted to join the register were significantly lower than the number eligible;

    2. Resolve who has accountability for contacting returners and commission a review of returner experiences to help shape a more effective and efficient deployment process, inform future communication strategies, reduce variation in onboarding and understand more about their personal experiences.

- More responsibility for operationalising and deploying staff from the temporary register (including pre-employment checks) should be delegated to local systems. This may enable the better matching of skills to clinical areas based on local need.

- Consideration should be given to using NHSP to support pre-employment checks at a local level.

- Consider using greater stratification of the recruitment to the temporary register, focusing on skills most needed at any given time.

- Consider specific communications from the CNO to existing nurses and midwives on the temporary register, and potential eligible returners, in addition to communications from the BBS campaign to maximise professional traction and engagement.

4.5 Nursing students

4.5.1 Development after the issuance of the 7-point plan

The CNO's first letter, the 4-point plan, reflected that the planned emergency legislation would allow the NMC to open a part of the emergency register for students. It also noted that students could be deployed through paid clinical placements. The later letter on April 6th (the 7-point plan) set out how paid clinical placements would be used for second- and third-year students.

Although the NMC did not open the temporary register to nursing students, confirming its decision on May 7th. The 11 DoNs in our acute focus group, and participants in our focus group with Heads of Schools of Nursing felt that the evolving approach had led to confusion, with the NMC decision coming 24 days after some students had started their clinical placements. However, the students we spoke to have told us that they understood the difference between the paid clinical placement and temporary registration.

HEE regional workforce leads told us that they felt that the national narrative during March changed from an initial focus on mobilising the biggest possible workforce in anticipation of students joining the temporary register, to a more considered view that students would not be needed to step into registered roles but should be invited to take up paid placements as staff could not be guaranteed to provide supervision for their supernumerary status.

The coordination between the Council of Deans, HEE and Higher Education Institutions was complex, especially given the pace of change. Regional HEE teams commented that they frequently heard things at the same time as students and HEIs which made it difficult for them to deal with queries. However, despite this it is clear from our fieldwork that the broad

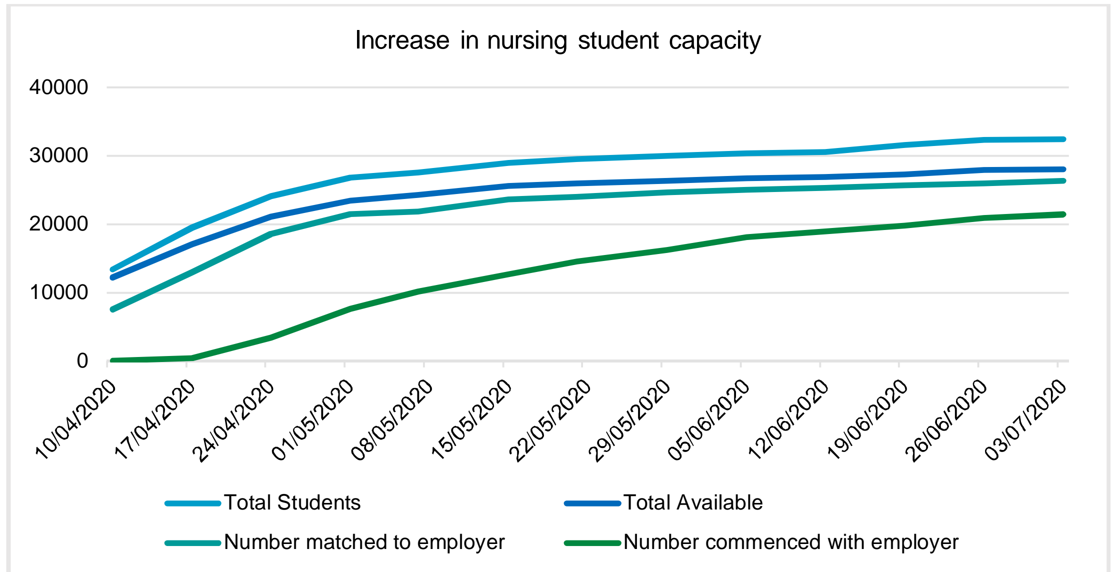
processes were clear, the HEE portal was a single source of data and that matching of students to placements and deployment got underway quickly.

We heard from student focus groups and academics from nursing schools that, despite national guidance being issued, there were examples of variation in the types of contracts nursing students were offered for their paid placements. Some providers and universities made demands for specific terms to be included or excluded in contracts, which added to the variation. Contract variations mentioned to the review group included paid versus unpaid academic hours, the exclusion of academic hours, zero-hour contracts and the exclusion of pension contributions.

4.5.2 Data

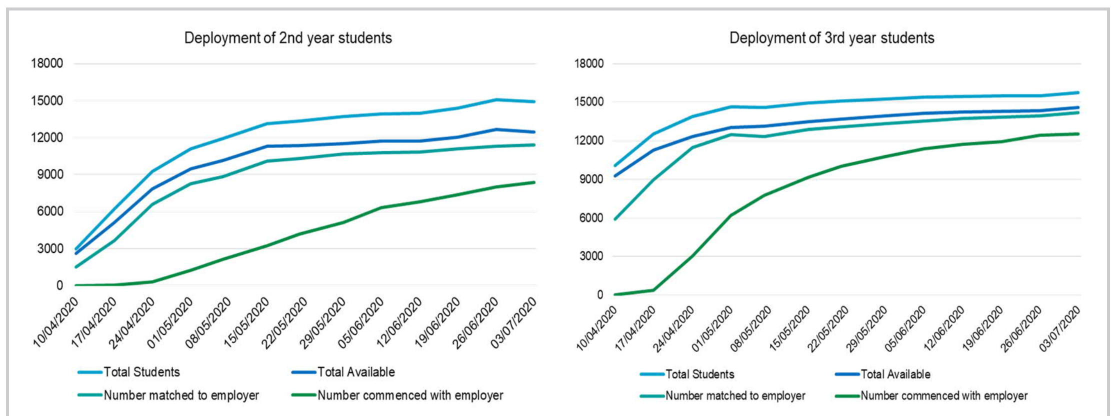
National, regional and local stakeholders have all indicated that, although they did not add to the registered nursing workforce, nursing students were successfully mobilised in line with the 7-point plan. 94% nursing students who volunteered to support during the pandemic and were put forward by their HEI, had been matched to an employer and 76% had started clinical placements by 3rd July (***Figure 6)*** This represents approximately 51% of the approximate 42,000 2nd and 3rd nursing students in the country. Whilst the data shows a high proportion of students were eventually employed in extended clinical placements, the figure illustrates that most students started their placement after the peak of the pandemic (in April and May) had passed. This corroborates the change in narrative behind student deployment reported by HEE regional teams.

Figure 6: Increase in nursing student capacity



The process for deploying third year students was faster than second years which was expected as the process is described as more intuitive based on their relative readiness to contribute during the response. Many HEIs also elected not to send their 2nd year nursing students out on placement due to their theory requirements. 50% of the third-year students in a paid clinical placement were in these positions by 1st May whilst only 15% of the second-year students were at the same time (Figure 7).

Figure 7: Deployment of nursing students overs time



4.5.3 Experience

Although there have been suggestions around process improvements, largely focussed on the HEE portal, feedback from DoNs we interviewed has been positive about the deployment of students. HEI representatives we have spoken to said that most issues raised on individual students' situation were resolved at local level. DoNs interviewed commented that although the approaches and system set up by HEIs varied and at times this caused confusion, overall the process of deploying nursing students strengthened the relationship between HEIs and DoNs. This view was echoed by the HEIs, who observed positive joint working across HEIs, CoDoH, HEE and providers.

Stakeholder interviews indicated that communication was a key challenge in employing nursing students. The Heads of Nursing Schools focus group commented that the communications sent to HEIs and providers were slightly different in terms of language and terminology, resulting in national letters and requests being enacted within different timeframes and in different ways by individual HEIs and providers. Differing views are held on the impact of this; some feel that a clearer national line on the timing of placements would have been helpful, whilst others feel that different university regulations were not well understood and communication improved once HEIs had been able to assimilate the impact and their approach. Therefore, employers interfacing with multiple HEIs were more likely to find this challenging.

Fieldwork completed with nursing students suggested there were inconsistent experiences of communication from universities. Students who had opted for the theory route, rather than paid clinical placements, were given conflicting messages from their universities and the NMC as to whether their simulation hours would contribute to the overall practice hours required to qualify. Students on the theory route felt there was a lack of support both academically and pastorally during this time and that they were given less consideration than students on clinical placement.

Despite national guidance being issued, there appears to have been significant variation in the types of contracts students were offered, student roles and responsibilities in practice and the inductions and educational support provided. After the announcement that some paid clinical placements were to finish at the end of July 2020, second year students were to revert to standard unpaid placements, while third year students would either be continuing their paid placements until September if they still had hours or assessments to complete for their degree or would be qualifying as Band 5 registered nurses had they completed their NMC required hours and assessments as per the programme validation. It has since been confirmed by HEE that nursing students paid placement contracts will be honoured up until the end of September 2020.

The ability to find suitable clinical placements in the community and mental health sectors which met the needs of the nursing student in term of their professional skills development was challenging. Models of care were significantly different with many services in the transition to a predominantly virtual care delivery approach and single attendance during domiciliary visits. This also meant that it was challenging to provide adequate opportunities and supervision to nursing students. It may have been helpful to consider whether a full range of placements was necessary or desirable or whether a set of prioritised areas might have been easier to mobilise.

Whilst most stakeholders believe that most students had positive experiences, the variation in the induction process, perceived equity across employment contracts and educational support provided to nursing students potentially impacted some students' perception of the experience. Stakeholders involved in the employment of students considered adequate pastoral support was provided by HEIs and providers. Students have indicated that a greater standardisation of induction, education and ongoing supervision would have improved their experience.

HEE workforce leads also emphasised the variation in student circumstances that had to be accommodated when arranging paid clinical placements, such as matching students to providers in different parts of the country/nations, understanding specific learning needs, meeting workforce demand, student and parent preferences, and students changing their minds and opting in/out of clinical placements. These challenges could have been mitigated by clearer, more consistent communications and SOPs across the regions. This view was echoed by the Heads of Nursing focus group who suggested that arranging out of area placements was challenging due to the regional variation in SOPs and culture.

There are different views as to whether students should have been able to choose which provider to take up their clinical placement with. Whilst HEIs believe that having to work with new providers created additional administrative burdens, others believe that restricting deployment locations may have prevented students from being allocated to areas of greatest need and impacted on the provision of placements suited to their students' professional developmental needs. There were also examples given by the Heads of Nursing and student focus groups where providers refused to accept out of area students, or indeed any nursing students on paid clinical placements, meaning students were forced to take the theory only route if their HEI would not facilitate placements with other providers outside their usual partners. HEI's also noted that they experienced significant additional work, but that no additional funding was provided to the HEI sector.

4.5.4 Legacy issues

There were discussions early on about the exit arrangements for nursing students from the arrangements introduced during the pandemic. But the different contracts given to nursing students and the different approaches used across HEIs has meant HEIs have been left with a complex set of different outcomes in regard to nursing students practice and academic hours. HEE stakeholders commented that universities are currently undertaking work to understand the position of all their students and put plans in place to support students to return to their expected completion trajectories.

There are concerns that the health and social care system will not be able to provide suitable clinical placements to meet the needs of the student nursing population in the 12-24 months to come. The changes to service provision together with the disruption to this years' placements, together with the increase in nursing students beginning new courses in September 2020, has created a high demand for placements. During interviews, some stakeholders from HEIs and providers have suggested there may be fewer placements available due to social distancing in community settings, increased use of digital services, elective and diagnostic services still not running and private and voluntary sectors focusing on 'getting back to normal'.

Despite the generally positive experience of students and providers, it is unlikely that students will be remobilised quickly in any subsequent waves. This disruption to training and the significant burden on both students and HEIs to recover the current position means that that the future NHS response to COVID-19 will most likely need to be undertaken without students.

Recommendations:

- When considering approaches for increasing the workforce for future waves or pandemics, consideration should be given to the disruption of nursing students' education and should not impinge on the student trajectory towards completion and permanent registration with the NMC.

5. Overall impact of the 7-point plan & monitoring

The constituent initiatives within the 7-point plan yielded varying numbers of additional staff as described the preceding sections of this report. This chapter will consider the impact of the seven points on the overall success of the plan at a regional and national level and how this impact was monitored.

5.1 Overall impact

Data shared by NHSE/I demonstrates that the nursing and midwifery workforce (defined as WTEs in post) expanded by 1.61% in April (n = 5,215) and 2.115% (n = 6,825) in May compared with a February 2020 baseline. Figure 8 below demonstrates the increase observed in the total nursing and midwifery workforce. Whilst encouraging, this was a small percentage of the potential workforce identified in the 7-point plan letter.

Figure 8: Change in nursing & midwifery WTEs in post from March to May 2020, in England

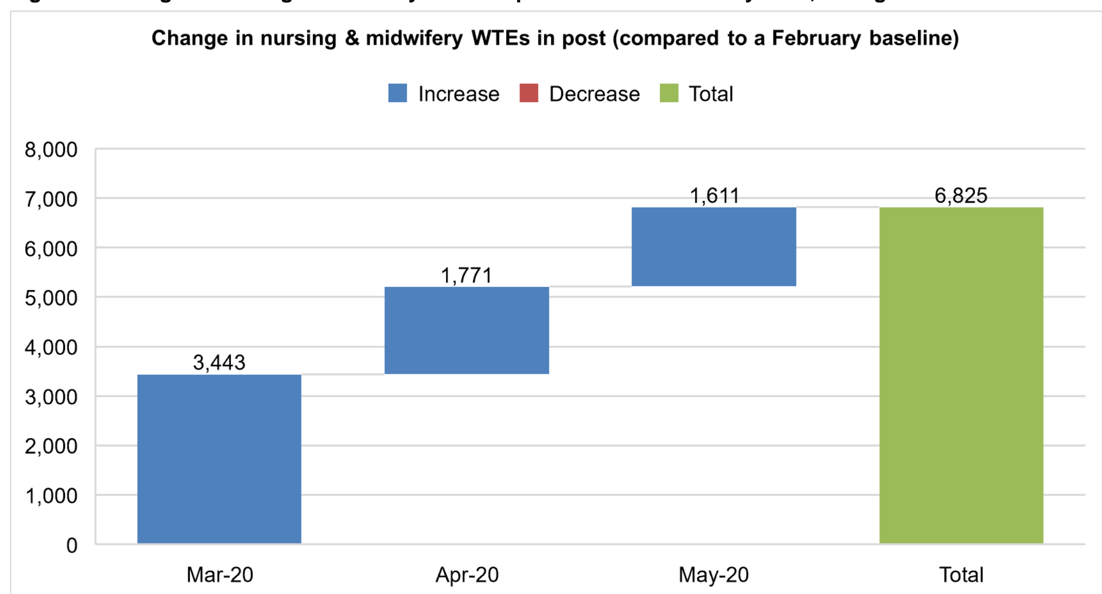
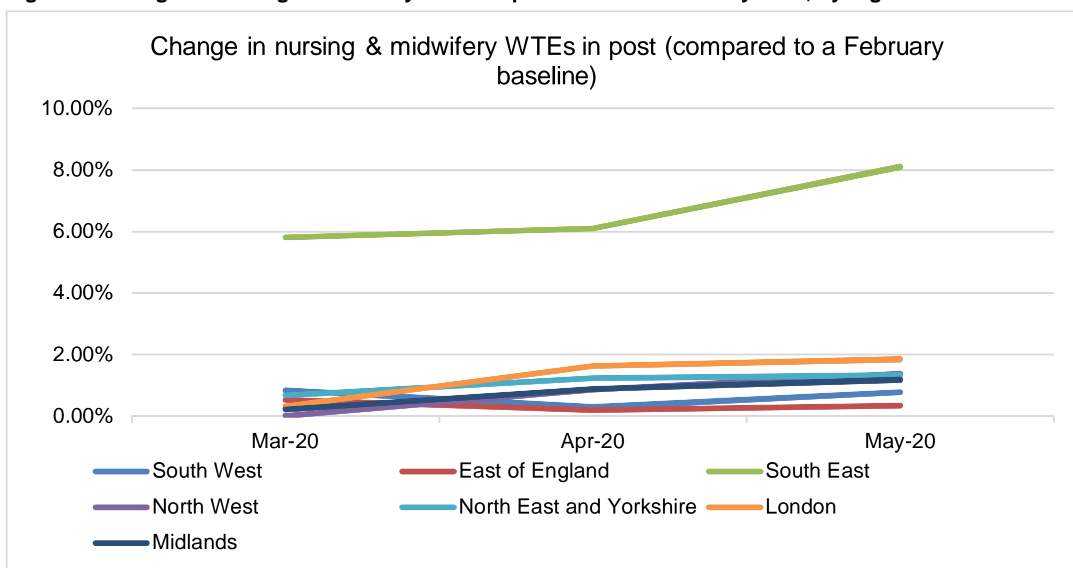


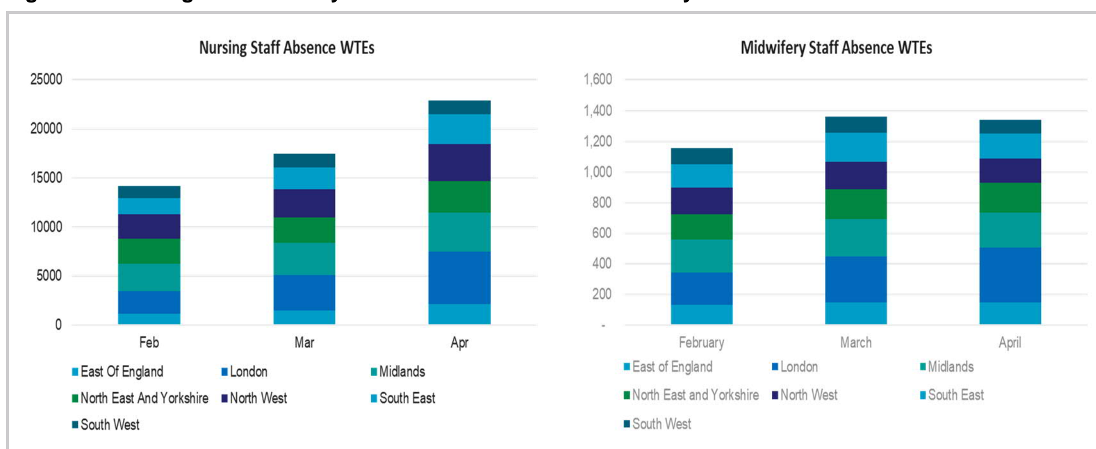
Figure 9 shows the regional variation in the expansion of nursing and midwifery capacity. The South East region expanded its nursing and midwifery workforce by 6.10% and 8.1% by the end of April and May respectively. Our fieldwork indicated that variation was thought to be related to the way the plan was operationalised at local level. Whilst we recognise that variation is sometimes needed to meet individual demands, unwarranted variation should be monitored and reduced.

Figure 9: Change in nursing & midwifery WTEs in post from March to May 2020, by region



While the data provided by NHSE/I demonstrates an absolute increase in nursing and midwifery staff in post over the course of the pandemic, the data also demonstrates the system was faced with a significant challenge caused by sickness. The Electronic Staff Record (ESR) from February to April data shows there were an additional 8,722 WTE days lost to staff absence in April 2020 (the latest data made available to the review group) above those in February for nursing and 186 WTEs more for midwifery , representing an increase in the sickness rate from 4.8% to 6.1% (Figure 10).

Figure 10: Nursing and Midwifery absence in WTE from March - May 2020



This means that by the end of April 2020, the increase in staff absence from sickness had exceeded the additional nursing and midwifery capacity in post by 3,694 WTEs, meaning the service actually had a net reduction in available hours. The data corroborates anecdotal feedback collected in the focus groups and national interviews indicating that there was severe strain on the nursing and midwifery workforce as a result of sickness. The regional variation is presented in Table 4 but shows a net reduction in hours across all regions.

Table 4: Shows the net impact of an increase in supply vs. increase in sickness, with increased supply referring to the incremental nursing and midwifery WTEs in post at the end of April compared to February (source ESR data)

Region	Net new supply (WTEs)	Increase in sickness (WTEs)	Net change in nursing and midwifery workforce (WTEs)	% change in nursing and midwifery workforce hours
London	982	3,267	-2,285	-3.90%
Midlands	532	1,256	-721	-1.22%
North East and Yorkshire	656	718	-62	-0.12%
North West	436	1,201	-765	-1.56%
South East	2,464	1,457	1,007	2.48%
East of England	58	956	-898	-3.04%
South West	84	95	-11	-0.04%
Other/unattributed	0	-41	41	N/A
Total	**5,215**	**8,909**	**-3,694**	**-1.16%**

While the ESR data highlights the impact of shielding/self-isolation provided to the review group was not broken down by region, the combined number of nursing and midwifery staff self-isolating across England was significant as demonstrated in Table 5. These numbers are in addition to the sickness rates in Table 4 and demonstrates an additional pressure on the service.

Table 5 :Total shielding and self-isolation WTEs from Mar – May (source: ESR data)

Month	Nursing and midwifery WTEs
Mar	12,263
Apr	26,737
May	19,609

While the data indicates high rates of mobilisation of nursing and midwifery students, the vast majority were not mobilised until after the peak of demand began to subside in May. Table 6 shows the cumulative nursing student employment numbers by month delineated by region. This should be considered when reflecting on the success of the plan and how it can be improved in the future.

Table 6: Cumulative number of nursing and midwifery students who started clinical placements by region

Region	April	May	June
East of England	526	1156	1546
London	1163	2848	3791
Midlands	1513	2975	3715
North East and Yorkshire	1588	3275	4162
North West	1719	3720	4515
South East	481	1083	1533
South West	658	1187	1647
Total	**7,648**	**16,244**	**20,909**

The workforce data perspective aligns with our field work findings. There is a marked difference between the numbers of staff mobilised through the centrally driven approach to the temporary register approach and ALBs compared to the relatively locally driven student mobilisation. Where additional registered nurses were recruited or redeployed, this was felt to be largely driven through local systems.

Whist some of our national interviewees suggested the small number of additional registered nurses was the result of lower demand than was anticipated, our local fieldwork suggested otherwise, and local leaders said that if staff had been available, they would have gladly welcomed the additional capacity. Our field work has led to the conclusion that many providers were able to find the capacity required to meet demand, but that some of the most impactful actions taken were not related to the 7-point plan. However, local leaders believe that additional capacity will be needed in the coming months to support recovery and potential future waves of COVID-19.

Recommendations:

- A minimum dataset that provides sufficient detail to monitor the supply of additional nursing staff in future responses should be agreed nationally and deployed across the system.

- Meaningful data should be used to review and refine the plan for future waves.

6. Conclusion

The Review Group recognise that the rapid onset of the COVID-19 pandemic meant decision-makers faced significant unpredictability and that decisions were made at extreme pace. While it was clear that there was a need to increase the nursing and midwifery workforce significantly, the CNO had limited data to inform decisions on the scale of the workforce expansion required. We were asked to review the operational delivery of the 7-point plan, to identify blockages and make recommendations for immediate improvement , review readiness of the profession for potential future waves of COVID-19, taking into consideration learning from the first wave, making recommendations for any changes or extensions to the plan and consider the professional challenges for nursing and midwifery during the recovery period as the NHS manages both COVID-19 and non-COVID-19 services across the system. The review group recognises the unprecedented situation the CNO was faced with, the huge uncertainty about how COVID-19 might impact the nursing and midwifery workforce as well as the demand for nursing care. The review group feels the 4 and 7-point plans identified a set of appropriate actions. We also note that the plan was developed following engagement with key UK-wide stakeholders.

The operational delivery of the plan would have been enhanced by detailed analysis of demand (both number required and skills), a focus on a flexible and resilient workforce, and early identification of implementation issues. The initial focus was on critical care capacity and a broader understanding of the impact of COVID-19 throughout the health and care system (while still acknowledging the priority of increasing acute and critical care capacity), would have broadened the focus to longer term capacity and recovery of services. In order to understand the impact of the plan, a comprehensive dataset and monitoring mechanism would have provided the CNO with the information to adjust the plan where needed.

Our fieldwork found that key stakeholders in the system were familiar with the individual components of the 7-point plan, but more could have been done to ensure a single, cohesive operational plan. We heard of inconsistencies and ambiguities between the messaging of the CNO and CPO teams. We also heard that communication with temporary registrants was infrequent and did not explain the delays in their deployment and that this may have increased attrition from the process.

Some of the initiatives outlined in the 7-point plan yielded more registered nurses than others. Redeployment of registered nurses by Directors of Nursing was perceived to have provided the most significant increase in staffing. We believe this will be much more challenging support later pandemic waves as services will not be shut at the same scale.

The deployment of nursing students, despite some communication and matching challenges, resulted in widely reported positive experiences for students and providers. Their deployment has provided an important opportunity for HEIs, HEE and the NHS to build improved relationships. However, despite this largely positive outcome, there is little appetite to consider future mobilisation of nursing students for future waves due to the impact on students’ education.

A low percentage of the eligible former nurses joined the temporary register. We heard that the centrally managed employment checks process was slow and the number of temporary registrants who made it into practice was low. Engagement with returners to understand their motivation and what they wanted to contribute was felt to be, at best, patchy. There appears to be little focus on increasing the number joining the temporary register or engagement with those currently on the temporary register, despite this route having the largest potential supply.

We have set out our recommendations at the end of each chapter. In considering our recommendations we have considered two timeframes: actions we believe should be taken now to improve the response for a second wave of COVID-19 and longer term actions which may have a longer lead in time but which we think should be considered to support future pandemic planning:

Recommendations to support future COVID-19 response:

- Risk assessments should follow a national framework, with version control, date of agreement and author details.
- Greater focus should be placed on clarifying accountability for specific actions.
- All communications should routinely be routed through the Incident Coordination Centre, with consistent and wider distribution lists reflecting the nursing and people responsibilities in operationalising a workforce plan.
- Minimum data sets monitoring the impact of actions should be agreed and communicated through the ICC. Where data is required from other ALBs or stakeholders this should be clearly agreed, documented and provided through a single route.
- Future plans should have a greater emphasis on identifying specific skills required at different stages of a pandemic and consider how this might modify the call for additional staff. This includes a recommendation for greater emphasis on all sectors of the health system (e.g. mental health, community services)
- Future workforce plans should be underpinned by risk assessments which address the impact on existing staff, returners and patients and should adhere to national pandemic risk assessment guidelines. The risk assessment should inform the prioritisation of different elements of the plan.
- Plans should include clear roles and responsibilities for implementation and communication, considering the role played by stakeholders at national, regional and local levels. This should include accountability for both delivering the plan and monitoring its efficacy.
- National minimum data sets on the recruitment and deployment of additional staff in a pandemic should be agreed.
- National guidance on the support required by registered nurses deployed through the Rapid Response Service should be provided.
- The CNO should:
    - Work with stakeholders to understand why the numbers attracted to join the register were significantly lower than the number eligible;
    - Resolve who has accountability for contacting returners and commission a review of returner experiences to help shape a more effective and efficient deployment process, inform future communication strategies, reduce variation in onboarding and understand more about their personal experiences.
- More responsibility for operationalising and deploying staff from the temporary register (including pre-employment checks) should be delegated to local systems. This may enable the better matching of skills to clinical areas based on local need.
- Consideration should be given to using NHSP to support pre-employment checks at a local level.
- Consider using greater stratification of the recruitment to the temporary register, focusing on skills most needed at any given time.
- Consider specific communications from the CNO to existing nurses and midwives on the temporary register, and potential eligible returners, in addition to communications from the BBS campaign to maximise professional traction and engagement.

- A minimum dataset that provides sufficient detail to monitor the supply of additional nursing staff in future responses should be agreed nationally and deployed across the system.

- Meaningful data should be used to review and refine the plan for future waves.

Recommendations to support future pandemic planning:

- We recommend that the CNO office work with the NMC to complete further analysis of the skills and availability of nurses on the permanent register but not employed by the NHS so that informed decisions can be taken as to whether this cohort should be specifically targeted (and if so, how) in future waves.

- Separate assessments for increased midwifery capacity (for example, to cover illness and those shielding) to be performed in future and discrete actions to be developed.

- NHSE/I should consider the development of a specific nursing workforce mobilisation plan as part of its overall Pandemic Plan. This should be developed jointly by the CPO and CNO teams with frontline engagement, including with staff who joined the temporary register.

- When considering approaches for increasing the workforce for future waves or pandemics, consideration should be given to the disruption of nursing students' education and should not impinge on the student trajectory towards completion and permanent registration with the NMC.

Appendix A Membership of the CNO 7-Point Plan Review Group

Name	Organisation	Role
Dr. Sarah Pinto-Duschinksy (Chair)	EY	Partner
Dr. Elaine Maxwell (Vice Chair)	NIHR Centre for Engagement and Dissemination (CED), National Institute for Health Research (NIHR)	Content Lead
Kate Shields	Royal Cornwall Hospital NHS Trust	CEO
Professor Oliver Shanley	North East London NHS Foundation Trust	CEO
Edmund Tabay	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Deputy Chief Nurse
Allison Cannon	Working together as Sussex NHS Commissioners, NHS Brighton and Hove CCG | NHS East Sussex CCG | NHS West Sussex CCG	Chief Nursing Officer
Steph Lawrence	Leeds Community Healthcare and Leeds GP Confederation	Executive Director of Nursing and Allied Health Professionals
Gill Hunt	NHSE/I	Senior Clinical Lead
Lorraine Sunduza	East London NHS Foundation Trust	Chief Nurse
Professor Melaine Coward	University of Surrey, School of Health Sciences	Head of School
Patrick Nyarumbu	NHSE/I - East of England	Director of Nursing Leadership and Quality
Professor Craig Harris	Wigan Borough Clinical Commissioning Group	Managing Director
Stephen Groves	NHSE/I	Director of EPRR (National)

Appendix B Chronology of key communications and events

9th March	**HEE discussion on use of students in pandemic response (Reference: HEE timeline)**
16th March	• NMC proposal to invite nurses/midwives to join the temporary register, whom had recently left the permanent register. This was agreed at a CNO conference attended by national stakeholders who were consulted on the plan. • Call between HEE, NMC and SMT outlining the three potential options for students of a paid clinical placement (ultimately agreed to be the most effective solution), stopping all training, or placing students on the temporary register. Reference: HEE timeline
17th March	• Letter issued by NHSE/I CEO and COO to Chief Executives and System leaders: 30,000 of English NHS's 100,000 general and acute beds required to increase capacity in the acute setting
19th March	• **4-point plan issued** to Regional Chief Nurses and Directors of Nursing • Joint statement (CNOs, CoDoH, NMC, RCN, UNISON, Unite) released on expanding the nursing workforce in the COVID-19 outbreak, outlining the working commitments agreed by key stakeholders • A letter was issued by the government on hospital discharge guidance to ensure that acute bed capacity is maintained • A follow-up to letter of 17 March, issued by Director of Community Health, outlining how community providers can release capacity to support during the pandemic
20th March	• Temporary register opens to nursing/midwifery voluntarily lapsed registrants (0-3 years) • NHSE/I returners process launched
22nd March	• NHSP rapid response service goes live
23rd March	• Internal NHSE&I redeployment launches
24th March	• HEE issue letter to Deans requesting they contact all 3rd year students about volunteering
25th March	• NMC Emergency Registration Policy approval, supported by government emergency legislation. The work undertaken to expand the nursing workforce was guided by the government Coronavirus Bill 2020 • Guidance produced by NHSE&I for providers to manage capacity across inpatient and community services • Critical care staffing framework issued by HEE, containing staffing structures and ratios • Joint statement (CNOs, NMC, RCN, UNISON, Unite, CC3N, BACCN, UKCCNA, Nurse Professional Advisory Group, National Critical Care Network) issued regarding developing immediate critical care nursing capacity • Principles for increasing nursing workforce issued by NHSE&I: critical care has a vacancy factor of almost 10% and BAU maintained by using bank and agency nurses • Joint statement (4 CNOs, 4 CMOs, CoDoH, NMC, RCM, RCN, Unite, UNISON) issued providing update in relation to nursing/midwifery students not in final 6m of programme • NMC and 4 CNOs agree approach of temporary registration of overseas trained nurses
26th March	• Agreement reached with DWP to second non-patient-facing clinicians to NHS – letter issued to c.1,100 DWP registered nurses.
27th March	• Temporary register launched - NMC writes to 51,000 returning nurses/midwives

31st March	• Update to Workforce Cell on progress on developing the CNO 7-point plan • Approval from Cabinet Office to launch NHSP advertising campaign
6th April	• **7-point plan issued** • 2,296 overseas applicants who had completed all parts of NMC process, apart from the OSCE, invited to join temporary register
8th April	• Workforce guidance produced by NHSE&I for mental health providers, regarding how to increase capacity outside of the existing mental health workforce • National staff side AFC banding agreement – NHS Staff Council issues guidance for employers on job descriptions and bandings for student paid placements
13th April	• Guidance release by NHSE&I for the safe deployment of staff • Third year student deployment starts
15th April	• Government releases COVID-19 social care action plan, stating that registered nurses will be deployed to support social care
30th April	• Updated guidance released by NHSE&I for the safe deployment of staff, following 13th April guidance. Now includes specific reference to the BAME community
7th May	• NMC, in collaboration with four CNOs, CoDoH, Royal Colleges and trade unions, makes decision not to establish temporary register for students
8th May	• Joint statement (CoDoH, NMC, HCPC, HEE, NHS Employers) issued regarding planned placements
17th June	• HEE release statement for nursing students regarding paid placements – student funding to end on 31 July
24th July	• NMC publishes EQIA (originally completed on 30th June), which covers issues including the diversity of the temporary register, the emergency education programme standards, and use of the emergency rules relating to fitness to practise

Appendix C Chronology of key communications and events related to students

9th March	The first formal consideration of utilising students to increase workforce capacity during the pandemic by HEE.
12th March	The four national CNOs, RCN, RCM, NMC and CoDoH issued a joint statement in support of registered nurses and midwives in the event of a COVID-19 epidemic in the UK, where it was stated that final year students would be invited into clinical practice over the 'next few months'.
16th March	HEE held a discussion with the Universities Alliance on the use of students to support the pandemic. Three options were considered by HEE, NMC and SMT: a) paid clinical placements, b) establishing a student part of the temporary register, and c) stopping all student training. As per a timeline provided by HEE, it was agreed on the 16th March that paid placements would be the most suitable option.
19th March	The option of establishing a student part of the temporary register was included in the 4-point plan. In addition, in a joint statement released by the four CNOs, CoDoH, NMC, RCN, UNISON and Unite, it was stated that 'the next stage of the COVID-19 temporary register would be to establish a specific student part to the emergency register for students in the final six months of their programme'. The responsibility for ensuring student deployment and communicating this appears unclear.
24th March	The HEE student database for nursing went live, and HEE issued a letter to all University Deans requesting they contact third year students to consider undertaking paid NHS roles to support the pandemic. This letter stated that 'the NMC is permitting third-year undergraduate nursing students in their final six months of training to be considered for a temporary NMC registration and be deployed in an enhanced role with NHS providers'.
25th March	The emergency standards for nursing and midwifery education were published by the NMC. They did not mention the possibility of students entering the temporary register. Indeed, they stated that programme providers must ensure that a 12-week period of practice learning was undertaken for entry to the NMC register for students in their final six months of training. On the same day a joint statement was released by the four CNOs, four CMOs, CoDoH, NMC, RCM, RCN, Unite and UNISON outlining the standards in place for students not in their final six months of training.
26th March	The CNO and HEE issued a letter to all nursing and midwifery students setting out the options for deployment. Students in their final six months of training would be able to opt-in to an extended non-supernumerary clinical placement on a band 4 salary. They may then later be able to join the temporary register, moving to a band 5 salary. However, it is important to note that student midwives did not have the option to join the temporary register, due to the autonomous role of the midwife.
27th March	HEE released student guidance.
2nd April	A joint statement was released by the four CNOs, four CMOs, CoDoH, NMC, RCM, RCN, Unite and UNISON providing an update on the further action being taken to expand the amount of people on the COVID-19 temporary register. This statement made clear that the decision to include students on the temporary register had not yet been agreed by the signatories of the statement and would be decided by the NMC in the following weeks.
4th April	The HEE student database for midwives and AHPs went live, 11 days after the nursing student database.
6th April	The 7-point plan was released. This plan detailed that second-year students would be offered to opt-in to a revised programme model, spending 80% of their time in clinical practice and 20% in academia. Third year students in the final six months would be given the option to spend the first 4-8 weeks in a Band 4 role and then following appropriate induction and governance, would voluntarily move to a Band 5 role.
8/9th April	Post-issuance of the 7-point plan, further communications were issued to universities and providers, such as the AFC banding agreement and associated employer guidance on the 8th April, and HEE guidance for return to practice students on the 9th April.

13th April	Student deployment started on the 13th April, seven days after the 7-point plan was issued.
7th May	The NMC made the official decision not to establish a specific student part of the temporary register for nursing students, after close collaboration with the four CNOs, CoDoH, Royal Colleges and trade unions. This was 24 days after some students started their clinical placements.