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Health and Social Care Committee Call for Evidence; Clearing the backlog caused by the pandemic

Introduction

The Royal College of Nursing is the largest professional body and trade union for nursing staff in the world. We represent around 465,000 members who are registered nurses, midwives, students, and nursing support workers. The nursing profession has been at the fore of the response to the pandemic, leading innovation and quality of treatment and care. Nursing staff play an indispensable role in delivering health and care services and they have gone above and beyond during this crisis to support and care for patients.

Our members, like all health and care staff across the UK, are exhausted. Many are experiencing the toll of months of unrelenting pressure through mental and physical ill health and burnout. As routine appointments, elective operations, and urgent cancer care start becoming business as usual again, all while Covid patients continue to need care too, nurses need immediate and long-lasting support to ensure we do not cause irreparable damage to the workforce that will impact the service for years to come.

1. **What is the anticipated size of the backlog and pent-up demand from patients for different healthcare services including, for example, elective surgery; mental health services; cancer services; GP services; and more widely across the healthcare system?**

The backlog of care and treatment is becoming more evident now as the NHS is experiencing a surge in demand for services. The RCN understands from the latest figures from NHS England that[1]:

- The number of people waiting to start consultant-led elective treatment has risen to a total of 5.45 million people at the end of June, the highest number since records began in August 2007.
- The number of people having to wait more than 52 weeks to start treatment was 304,803 in June – more than six times the number in June 2020 (50,536).
- 230,110 urgent cancer referrals were made by GPs in June, up 50% from the 153,543 reported in June last year.

While these figures are staggering, the RCN considers that they are not necessarily a true indication of the type of effort and resources – including registered nurses and nursing support workers - that will be required to address the backlog safely and effectively. For example, these figures do not show how many of the people waiting for services now have health concerns that are more serious or complex than they would have been had they been treated earlier. Additional complexity in what would normally

[1] Statistics » Combined Performance Summary (england.nhs.uk)

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be routine cases can require not only more time to resolve, but a more specialised and skilled workforce too.

These figures do not take account of the number of cases that may be treated in different settings or manners now than they would have done before the pandemic. Ensuring optimum infection control in secondary care settings, the increased use of telemedicine and a continued preference towards community-based care will all be components of both new cases and addressing the backlog for months to come. It is unclear how these ways of working may place additional pressures on some parts of the system while relieving pressures in others.

These figures do not capture the amount of people who are still hesitant to request healthcare services for fear of being exposed to Covid-19, and they do not take account of potential further waves of the pandemic as well as the annual winter pressures that are likely as we move into 2022.

Without more detailed data on the types of cases and concerns involved in this backlog we are concerned that addressing the backlog may fall more disproportionately on some parts of the nursing profession, which is already suffering from significant recruitment and retention challenges and risks.

2. What capacity is available within the NHS to deal with the current backlog? To what extent are the required resources in place, including the right number of staff with the right skills mix, to address the backlog?

The RCN has significant concerns that nursing capacity is at critical levels and shows no signs of improving in time to deal with the current backlog.

Existing high vacancies and increased demand from Covid means that current registered nurses have been expected to shoulder a large amount of the workload during the last 18 months. Prior to the onset of the pandemic there were 50,000 nursing vacancies in the NHS across the UK, and Skills for Care estimated there were 122,000 vacancies in social care. At this time, our members were already telling us that many of them were significantly overworked. In 2019, our employment survey showed that 77% of nursing staff worked in excess of contracted hours at least once a week; 39% did so several times a week and 18% worked additional hours on every shift[2].

We consider that the risks our members reported to us prior to Covid have at least continued if not significantly worsened over the last 18 months. While some additional support from professionals from the Nursing and Midwifery Council's (NMC) Covid-19 temporary register has been made available, a third of nursing professionals who responded to an RCN survey during the pandemic reported that they were working more

[2] Royal College Of Nursing (2019) *Employment Survey 2019 Available* at https://www.rcn.org.uk/professional-development/publications/pub-007927

hours than before the pandemic. Indeed, over a third of our members who responded (38%) say staffing levels have worsened compared to before the pandemic[3].

The RCN is concerned that this increased workload that has been placed on an already overstretched nursing profession is now the beginning of a much larger retention and recruitment issue, in the context of not enough registered nurses guaranteed through a sustainable pipeline of supply. In our survey, three quarters of nursing staff told us their stress levels were higher than before the pandemic and that this is a major reason for now considering leaving the profession. Overall, 44% said that the way nursing staff have been treated during the pandemic has made them consider leaving the profession and those aged under 24 are most likely to cite staffing levels as a reason for wanting to leave.

Data from the NMC has shown that the amount of nursing professionals joining the register during the pandemic has decreased but this has been offset by the amount of people leaving the register also decreasing. This is thought to be short term and principally aligned to a number of registered nurses who would have considered leaving over the past 18 months deciding to delay doing so to support the Covid efforts, however there is now a risk that we could see nurses from all levels of the profession now choosing to leave as the pandemic 'eases'.

Any vacant post, in any setting, threatens the quality of care patients or individuals receive and compromises their safety. However, there is a body of evidence that shows a direct link between nursing staffing levels in particular and patient safety outcomes. This includes a report from 2019[4] which showed that for every day that a patient was on a ward which had fewer than the average number of nurses, their chance of dying increased by 3%. As cutting down the backlog of cases becomes an increasing priority, and as pre-pandemic vacancies become exacerbated with more people considering leaving the profession, it has never been more important for the Government to take rapid action to deliver a fully funded and modelled demand-led workforce strategy.

We propose that to tackle workforce shortages, clear legal duties and accountability for all those who contribute to workforce supply and planning, is created through primary legislation. This includes accountability for provision of workforce living with the Secretary of State for Health and Care, explicitly. The RCN is urgently requesting that Government should publish a costed and fully funded workforce strategy, with both short- and long-term solutions for supply, recruitment, and retention for the full range of health and care systems. The ask is also for a reduced over-reliance on international recruitment which is not sustainable especially while the pandemic is still acute globally.

The RCN welcomes and values international colleagues and is sensitive to the World Health Organisation's recently published global strategic directions for Nursing and Midwifery[5]. In it the WHO clearly calls for all nations to increase the availability of health

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[3] Royal College of Nursing (2020), Building a better future for nursing: RCN members have their say, https://www.rcn.org.uk/professional-development/publications/rcn-builiding-a-better-future-covid-pub-009366

[4] Griffiths P, Maruotti A, Recio Saucedo A, Redfern O C, Ball J E, Briggs J, Dall'Ora C, Schmidt P E, Smith G B and Missed Care Study Group (2019) Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study, BMJ Quality and Safety, 28(8), pp. 609–617.

[5] https://apps.who.int/iris/bitstream/handle/10665/344562/9789240033863-eng.pdf

workers by sustainably creating nursing jobs, effectively recruiting and retaining nurses, and ethically managing international mobility and migration. This includes a specific policy call for countries to conduct nursing and midwifery workforce planning and forecasting through a health labour market lens.

Without sufficient and meaningful efforts to grow the nursing workforce, and retention measures, the current staffing shortage is only set to increase. Recent figures from Macmillan Cancer Support state that by 2030, there will be approximately 3.3 million people living with cancer in England. Without any action to increase the workforce, the gap between projected patient need and workforce capacity will grow to 3,371 nurses, a 100% increase over current numbers of specialist cancer nurses[6]. This same Macmillan research shows that among people who are recently diagnosed with cancer in the UK who did not receive enough support from a specialist cancer nurse, almost half (44%) said this led to either being unsure on treatment side-effects, attending A&E or being unsure if they were taking their medication correctly. All of these outcomes can be costly on the system and impact patient outcomes. It is clear that the system as it is, is now not coping and is also not sustainable against other predicted population developments. It is therefore clear that there is not sufficient nursing capacity available within the NHS to deal with the current backlog.

3. How much financial investment will be needed to tackle the backlog over the short, medium, and long-term; and how should such investment be distributed? To what extent is the financial investment received to date adequate to manage the backlog?

Retention of nursing staff must be a key financial priority for government over the coming months. There is a high risk that without effective and fully funded initiatives that support the wellbeing and development of current staff, the capacity to address the backlog will decrease.

In our survey of nursing staff during the pandemic, 74% of respondents felt more valued by the general public, 58% stated they felt more valued by the media and 54% say they felt more valued by patients or people who use services compared to directly before the pandemic. However, just 18% stated they felt more valued by the government in their part of the UK.

Nearly three quarters of respondents (73%) said higher pay would make them feel more valued. This is true for all staff in every sector of health and social care, whether they are considering leaving the profession or not.

Nursing is a safety critical profession, vital to our country's wellbeing and to addressing the backlog of non-urgent care. It is a highly skilled, modern profession which deserves fair pay that reflects the complexity and impact of its contribution. The lack of adequate pay for nursing staff, and lack of parity in pay terms and conditions across services without direct NHS provision too, has a damaging impact on staff recruitment and

[6] https://www.macmillan.org.uk/assets/forgotten-c-nursing-report.pdf

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retention, as well as impacting on the mental health of nursing staff, causing them additional stresses and leading them to work additional hours or second jobs.

In August 2020, we launched the *Fair Pay for Nursing* campaign, aiming to secure a fully funded 12.5% pay increase for all nursing staff covered by Agenda for Change terms, as part of a one-year deal that applies equally to all pay bands. Any pay rise must not be funded through existing budgets.

Based on analysis of NHS workforce numbers and earnings data undertaken by London Economics, a 12.5% pay rise for all Agenda for Change staff working in NHS trusts and support organisations in England shows that the cost to the Exchequer would be approximately £4.25 billion extra per year. The Barnett consequentials associated with a 12.5% pay rise is estimated to be an additional £802 million.

The economic disruption of COVID-19 has left the UK economy in recession, however government spending in the form of NHS pay rises could act as stimulus to boost the economy. Evidence from the Institute for Fiscal Studies shows that the NHS acts as an economic 'anchor institution' in areas of higher deprivation due to the job opportunities it provides, as it employs more people at a higher wage levelling up the local economy. Many of these more deprived areas are likely to suffer some of the worst economic fall-out from COVID-19[7].

Morale and productivity are known to be correlated with job satisfaction and feeling valued. One study suggests that a "25 percent increase in nurse job enjoyment over a two-year span was linked with an overall quality of care increase between 5 and 20 percent"[8]. The same study says that "nurses' intent to stay increased by 29 percent". Similarly, research from the OECD shows that higher pay can increase the potential supply of new entrants to the profession.[9]

4. How might the organisation and work of the NHS and care services be reformed in order to effectively deal with the backlog, in the short-term, medium-term, and long-term?

It is vital that addressing the backlog should not come at the expense of the wellbeing and safety of the health and social care workforce. Nursing staff who have worked through the pandemic have faced intense psychological pressures and witnessed traumatising situations. Expecting registered nurses and nursing staff to continue to push themselves even further to now cut down the backlog is short-sighted and is a risk to the safety of staff and, equally importantly, patients alike. We have seen an increase in RCN Counselling referrals for workplace traumatic incidents and for the intensity of these incidents. This corresponds with evidence of increased work-related stress, burnout and mental health problems in the pre-pandemic period.

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[7] The Institute for Fiscal Studies, *The geography of the COVID-19 crisis in England*, 2020 [available at: https://www.ifs.org.uk/inequality/the-geography-of-the-covid-19-crisis-in-england/]
[8] Why Nurses' Job Satisfaction Matters to Patients. https://www.americanmobile.com/nursezone/nursing-news/why-nurses-job-satisfaction-matters-to-patients/#sthash.y4huBpol.1ij37jv1.dpuf
[9] OCED, The Impact of Pay Increases on Nurse' Labour Market, [available at: https://www.oecd-ilibrary.org/social-issues-migration-health/the-impact-of-pay-increases-on-nurses-labour-market_5kg6jwn16tjd-en]

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NHS and care services must be reformed to guarantee appropriate rest and recuperation for health care staff. There must be funded and supported time out – not limited to annual leave – for all staff, regardless of where they work and for those who have been impacted by COVID-19. This approach should include enabling staff to take breaks at work, and by reviewing and controlling working patterns to prevent long shifts or excess hours being worked.

Again, there is a body of evidence linking the health and wellbeing of the nursing workforce with patient outcomes, therefore for the benefit of both staff and patients it is essential that staff are supported to recover and work in a safe environment. Patient treatment and care should not be driven by financial or political targets. The focus in the short to medium term needs to move away from arbitrary targets and be driven by patient need and the ability to safely staff services.

As part of the reopening of more non-urgent services we are calling for risk assessments to be carried out and acted upon to ensure the safety of all nursing teams. Occupational health services must be available at the point of need to support the psychological and physical wellbeing of staff. All employers must make available and fund timely access to confidential counselling and psychological support for all staff. Staff must be able to self-refer and any barriers that may prevent nursing staff from accessing these services are addressed by government and employers.

It is essential that this access to psychological support and counselling is also made available to staff working in social care and other independent settings. Employers in the independent sector often lack the same infrastructure as the NHS in terms of occupational health provision and lack the funding to implement the same initiatives to tackle burnout and improve staff resilience.

Services must also consider the impact of long-covid in how they organise and support their staff as they address the backlog. Long-covid will continue to affect patients requiring treatment and will also impact staff directly. Long-covid must therefore be recognised as an occupational disease requiring appropriate policy, occupational health and support.

The increased risks faced by Black, Asian, and minority ethnic (BAME) nursing staff must be given particular consideration in this respect. Employers and governments must tackle the underlying causes which have contributed to worse health and wellbeing outcomes for BAME staff.

Long-term, government, together with employers, must address the issue of inconsistent access to supervision, preceptorship and support amongst the nursing workforce. Supervision provides a safe environment for reflection on practice as well as exploring emotional reactions to the work.

5. **What positive lessons can be learnt from how healthcare services have been redesigned during the pandemic? How could this support the future work of the NHS and care services?**

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The RCN has long supported closer integration between health and care services and efforts to reduce bureaucracy within the system. The pandemic frequently and clearly highlighted the negative impact which occurs when the NHS and social care services are not joined-up. We welcome the various local, regional and national initiatives throughout the pandemic to work across existing siloes for the benefit of patient safety. We are hopeful that integrated care systems (ICS) can be further embedded and developed so that the government can address the backlog, improve efficiency, address health inequalities and future-proof against future variants.

We also note that in response to the emerging pressures, the professional regulator the Nursing and Midwifery Council was required to make swift changes and reforms in order to support nurses and healthcare services. Ensuring that professionals are supported and encouraged in a culture of learning, and that regulators consider the context with which registered nurses and nursing staff operate, is always important but even more so during a global pandemic. We are hopeful that the upcoming reforms to professional regulation will continue to build on these changes and ensures that there is an understanding of the changing health and social care environment and it can evolve and reflect this, or regulation potentially becomes a risk in itself too.

We have also welcomed the increased profile and importance that has been shown to the nursing profession during the pandemic and we hope to see this reflected in how healthcare services are designed or redesigned moving forward. The nursing role has significantly progressed from its origins as a profession and the pandemic response has shown it to be the highly skilled clinical vocation that it is. Nursing has been central to infection control, the rollout of the vaccine, track and trace, coordinating on critical care wards and being responsible for the other 'business as usual' activities that had to be maintained regardless of the pandemic.

Despite being a safety critical and essential role in multidisciplinary teams, that identity has not always been mirrored in the views of the public nor in how services are structured and commissioned. Nurses can bring unique perspectives and skills to leadership positions within NHS services. The perspective of the nursing profession should not be ignored if we want to remember the hard learnt lessons from the pandemic.

6. How effectively has the 111 call-first system for A&E Departments been? What can be done to improve this?

The RCN does not have specific evidence to respond to this question.

7. What can the Department of Health & Social Care, national bodies and local systems do to facilitate innovation as services evolve to meet emerging challenges?

The nursing workforce is uniquely positioned to understand local population need and identify opportunities for joining up relevant parts of the patient pathway, across

settings and traditional boundaries. They play a crucial role in keeping people well, facilitating supported self-management of those with long-term conditions, running diagnostics, holding caseloads, preventing re-admission (where inappropriate), effective discharge, prescribing – everywhere a patient is in contact with an element of the system, there will be the presence of nursing staff. As such, providing clear support for visible nursing leadership and innovation would be a wise use of resources in addressing the backlog as well as delivering many broader healthcare ambitions.

Registered nurse leaders can transform systems to ones which prioritises prevention, health promotion and public health. This has great benefit to local health economies, in terms of preventing avoidable ill-health and ensuring that people are supported and cared for in the places most likely to contribute to effective treatment, rehabilitation and recovery, providing support for the population at all stages of life.

Nursing staff across organisations must have the opportunity to inform and agree to recovery plans that include a phased approach to the reintroduction of services, enabling staff to adapt to the change. Plans must consider 'lessons learnt' regarding new ways of working and take opportunities to provide efficient and effective services to patients within an agile and responsive working environment for staff.

We know that there is variation in how registered nurse leadership is embedded in existing local structures and it is critical to have a consistent approach and role for nursing leaders.

8. To what extent is long-covid contributing to the backlog of healthcare services? How can individuals suffering from long-covid be better supported?

The RCN is particularly concerned about the impact of long-covid and the need for this to be factored into recovery plans. The introduction of specialist clinics is welcome but these need to be scaled at pace to meet growing demand[10].

The impact of the pandemic on primary care and community services has been less public but no less significant. These services continue to manage far more patients than pre-pandemic in their own homes, to alleviate pressure on inpatient beds. And as with many long-term conditions, effective self-management and support in the community will be a crucial part of supporting those with long-covid.

Registered nurses therefore should play a unique and significant leadership, practice and research role in this emerging area of concern. However, this needs to be considered alongside the demand on an overstretched nursing workforce. The RCN is calling for more research to be carried out on long-covid, to understand its impact on the workforce and its wider public health implications.

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[10] ONS figures show that long covid cases were at 970,000 people in September 2021, an increase from 945,000 people in August 2021
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/2september2021

Long-covid must also be recognised as an occupational disease requiring appropriate policy, occupational health and support. The government should conduct a full assessment on how many healthcare professionals are themselves managing the effects of long-covid.