Royal College of Nursing response to Health and Social Care Select Committee inquiry on the Department of Health and Social Care White Paper 2021.

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

Summary

The RCN is supportive of the broad aims of the white paper to enable greater integration, reduce bureaucracy and put population health at the core of all decision making. However, there are several proposals which either do not go far enough or where we require further clarity or assurance: workforce demand and supply, professional regulation, service reconfiguration, acute care discharge and the Health Services Safety Investigations Body. As well there are further areas which need to be addressed through secondary legislation and guidance. In particular, the role of nursing leadership in new ICS structures and the importance of the nursing voice at all levels of planning and delivery.

While the remit for most of the proposals is England, for those that impact on other countries of the UK, there should be a requirement for agreement and consultation with the relevant devolved administration(s). In particular this should include the proposals regarding professional regulation and arms-length bodies.

Is it also important to note that for public health and social care, it has been challenging to fully assess the proposals in this white paper without an understanding of the broader changes expected later this year.

1. Overarching views on white paper proposals

1.1. *Proposals to facilitate collaboration and integration*

1.2. The RCN has long supported closer integration between health and care services and efforts to reduce bureaucracy within the system. We have recognised the gaps and duplications which occur when services are not joined-up and the negative impact this has upon patients.

1.3. We believe that integrated care systems (ICS) have the potential to unlock benefits for the population in terms of refocussing towards public health, prevention and health promotion. Nursing has a unique, cross-

pathway and cross-system perspective and will have a significant role in real system transformation.

1.4. *Further detail is needed on related areas of reform*

1.5. The scope of the proposals set out in the white paper is predominantly focussed on the NHS. Without further detail on the reforms for social care, public health and professional regulation it is not possible to make a full assessment.

1.6. Effective integration is reliant upon sufficient funding for all parts of the health and care system, including that required to enable staffing for safe and effective care. The National Audit Office identified that "*Many authorities are setting budgets for 2021-22 in which they have limited confidence, and which are balanced through cuts to service budgets and the use of reserves*". [1] The NHS Long Term Plan was based on a commitment that social care funding would not impose additional pressures on the NHS[2]. At this point in time we know that this is not the case in many parts of the health and care system, and we do not have assurance that either funding or workforce has been secured for public health or social care. We provide more detail on these issues in section 3.

1.7. The context of the COVID-19 pandemic, provision of safety equipment and safely ventilated buildings, recovery and clearing the backlog is an additional financial consideration. Some providers within the ICS are likely to have significant needs for additional support to clear their backlogs, and this will have implications for the overall ICS budget. Funding decisions at national level should be reflective of these additional needs.

1.8. *Nursing voice and leadership must be embedded in new structures*

1.9. While we recognise the need to focus on the primary legislative elements first, we raise now our expectations that nursing leadership is embedded into the ICS structures, at board level on a statutory basis, and throughout the component parts.

[1] National Audit Office (March 2021) Local Government finance in the pandemic. Available at: https://www.nao.org.uk/report/local-government-finance-in-the-pandemic/

[2] NHS Long Term Plan (2019) "*When agreeing the NHS' funding settlement the government therefore committed to ensure that adult social care funding is such that it does not impose any additional pressure on the NHS over the coming five years. That is basis on which the demand, activity and funding in this Long Term Plan have been assessed."* Available at https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

1.10. Nursing leadership is vital to delivering many of the ambitions of integrated care, and the Long Term Plan for the NHS. Nurse leaders are well placed to understand both the health and care needs of their populations and identify opportunities for joining up relevant parts of the patient pathway. We also know that nurse leaders can transform systems away from a focus on acute services and treatment to one which prioritises prevention, health promotion and public health. This has great benefit to local health economies, in terms of preventing avoidable ill-health and reducing the burden on expensive secondary services.

1.11. We know that there is variation in how nursing leadership is embedded in the existing ICSs, and this will lead to variation in quality and safety of care and in health outcomes. Although we recognise the need to allow flexibility at local level to determine approach, it is critical to have a consistent approach and role for nursing leaders. Current CCG structures have a statutory requirement for registered nurse representation on the board; a similar approach should be in place at ICS level.

1.12. Nursing leadership should be embedded throughout ICS structures, as well as within executive or decision-making functions. Nursing expertise is critical to ensuring decisions are made in the best interests of patients. This is a valuable component which needs to be protected at all levels, and in all types of settings. Nursing staff describe their experiences within current structures in which the nursing voice in community settings and primary care is often lost to medical perspectives. It is important that both are represented, along with other health professions.

1.13. *Opportunity to update local authority roles*

1.14. The approach taken in the white paper focuses almost entirely on the future roles and structures of NHS bodies, and does not include equivalent legal changes for local authorities. Our members have described variation in the level of engagement and collaboration between NHS bodies and local authorities.

1.15. We know that partners within the developing ICS are constrained by meeting their financial targets and obligations. This often comes at the cost of closer integration and budget sharing. This can hinder their ability to truly collaborate. While the white paper does resolve some of these issues within the NHS partners, there is a risk that the same pattern will continue on the local authority side.

1.16. We challenge the decision not to make the reciprocal changes to local authority commissioning and accountability, as we have seen proposed for NHS bodies. Changes to the roles, responsibilities and structures of local authority commissioning would better allow them to integrate into ICS. Without this, there will be different requirements of each body, limiting opportunities for effective integration. We are concerned that failure to align the commissioning functions of local authorities with NHS structures will lead to a two-tier system where the main focus of activity is on the provision of health services. This will risk siloed working and a limit for ICS structures to completely integrate services in their locality.

2. Specific feedback on individual proposals

2.1. *Workforce demand and supply planning*

2.2. We are supportive of the government taking steps to clarify the roles and responsibilities for workforce planning and supply. The RCN has long been highlighting the limitations of existing decision-making structures and their failure to produce sufficient workforce supply or a workforce strategy. We believe the proposed document clarifying roles and responsibilities will go part of the way towards focussing the system on tackling workforce issues.

2.3. However, the white paper proposal does not allow the Secretary of State to assign new functions which do not already exist in statute, nor define the parameters for responsibilities. Our view is that current legislation is missing key functions which would allow the system to take more strategic action on workforce planning as part of integrated service and finance planning, for immediate and longer term health and care delivery requirements.

2.4. Over the last decade we have seen widespread decline in parts of the nursing workforce and high numbers of vacancies in the NHS (currently 36,214 FTE registered nurse vacancies)[3]. In the last year, the total number of full time equivalent (FTE) nurses working in the NHS has increased by 3%, and since data reporting began in 2009, there has been a 10% increase.

2.5. However, the vacancy rate has remained relatively stable over the last few years and there are areas of nursing which have seen huge decline in the workforce, particularly in community settings. The total number of nurses working in the community has declined by 4% since 2009, with

[3] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---december-2020

District nurses declining by 42%, School nurses by 29% and Health Visitors by 18%[4].

2.6. These figures indicate that existing powers, duties and accountabilities to assess workforce demand and plan for supply are insufficient. The system does not proactively respond to downward supply trends in the context of increasing demand. A key missing duty is the requirement to undertake a population-need based assessment of present and future workforce needs, and to produce costed recommendations, to support national finance and policy planning.

2.7. This is necessary to inform decisions about the level of investment needed, future workforce supply requirements and the development needs of the workforce. Currently, decisions about workforce are often made within existing funding envelopes. This does not allow for service planning to meet the needs of the population now or in the future to be credibly undertaken and understood. A requirement to undertake an assessment of workforce based on population needs will allow for meaningful discussions to be undertaken on additional investment.

2.8. This legislative opportunity should be taken to assign an additional duty to the Secretary of State for Health and Social Care to undertake an assessment of current and short term, and long term, future workforce provision, at regular intervals.

2.9. There is a clear rationale for this additional duty – to resolve what current legislation does not currently provide for. It will allow assumptions about future workforce trends to be tested. This will give assurances about staffing levels, skill mix, capacity and workload (including non-patient facing time). In future situations, such as a pandemic, the impact of factors affecting productivity can be modelled; for example, if staff need additional time to comply with infection prevention controls. It will also allow for reassurance that targets are achievable, and will help identify where efficiencies can be made. Services and systems will then be better placed to make informed decisions about workforce needs, and therefore overall service and staff development funding levels.

2.10. The workforce assessment should be independently verifiable. This will allow for assurances to be made about the credibility of the assumptions and findings. This will include ensuring that the assessment reflects the drivers of recruitment and retention of different age groups

[4] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/november-2020

within the workforce. It should also take into account turnover and attrition rates of supply routes in order to get an accurate assessment of future education route output joining the workforce. Assumptions relating to the reliance on international supply routes can also be tested to ensure that they comply with UK Government obligations to ethical international recruitment, and for sustainable domestic workforce planning.

2.11. Plans and models for future workforce supply should be tested to ensure that all options have been considered. For example, if it is identified that domestic workforce supply is insufficient, has there been a reciprocal increase in domestic training places, rather than immediately moving to increasing international recruitment Another example is ensuring that all methods for increasing retention have been utilised, including those related to pay, terms and conditions.

2.12. This duty should cover the workforce in all types of publicly funded health and care settings. Our view is that this duty should cover a period of at least five, and up to twenty years into the future, in order to give sufficient data upon which strategic decisions can be made. The workforce assessment should not be undertaken in isolation, but integrated into wider decision making on service, finance and resource planning. To be effective, this will involve also integrating and sharing information with planning being undertaken at regional, ICS and provider levels.

2.13. Proposed additional duty: The Secretary of State's duty as to undertake regular workforce assessments:

1 The Secretary of State must undertake an assessment of future workforce demand and supply requirements for the health and care service in England, for the purpose of short, medium and long term integrated service, financial, and workforce planning for both annual and any multi-year service planning, not less than once every 5 years. The Secretary of State must secure independent assessment and verification of the findings prior to publication. Following independent scrutiny, a report based on the assessment undertaken in subsection (1) must be laid before Parliament.

2 The report must include recommendations for UK Government policy interventions to ensure future workforce supply and additional funding requirements.

3 The Secretary of State must keep under review any such events which may impact the accuracy of the workforce assessment.

4 In discharging this duty they must have regard to:

a) The projected health and care needs of the population, and workforce demand and supply, for the following 1-5 years, 5-10 years and 10-20 years.

b) Workforce demand and supply trends for the previous 15 years

c) Local, regional and national assessments and plans for service, workforce and finance planning, including workforce development requirements

d) Any factors negatively affecting productivity

e) Staffing levels and skill mix for safe and effective care

f) Reducing inequalities within the workforce

g) Existing UK Government obligations to adhere to ethical international recruitment practices

2.14. *Professional regulation*

2.15. The white paper sets out intention to introduce new powers for the Secretary of State for Health and Social Care to remove a profession from regulation, to abolish a regulator, to have restrictions lifted on delegating functions through legislation, and to include senior NHS managers and leaders and other groups of workers. The intentions for specific reforms are not set out, though we understand there will shortly be a consultation on proposed reforms to the regulatory landscape.

2.16. As the UK nursing professional body, we therefore set out the following position at this stage of the process, which we will pursue through the stages of the Bill and beyond. We would expect to see policy intentions such as criteria for removal of a profession from regulation to be set out alongside the Bill. We note that existing legislation across the UK will present areas of interdependency and overlap, for example regulation of 'professions' is a reserved matter under Scotland Act 1998. We therefore look for this Bill and its development to fully articulate the complexities of a UK regulated workforce in a devolved settlement going forward as required.

2.17. We are clear that nursing professional regulation should not be 'diluted' through joining the regulator of any other profession. Given the current focus on improving professional regulation, there is a clear opportunity to understand how the regulation of nursing professionals can be improved for meaningful public protection and professional registration.

2.18. The power to delegate functions provides the opportunity to delegate a greater role for professional bodies to determine UK applicable standards of education and training, and standards of conduct and performance. Many medical Royal Colleges already have the power to set mandatory standards –and we seek parity with the existing legal provisions that enable them to do this. For nursing, this should include standards for advanced nursing practice and nursing specialisms. The legislation should therefore support delegation to professional bodies. As an example, we will shortly publish new nursing workforce standards, setting out principles for workforce planning, based on nursing professional expertise, and the current evidence base. These will demonstrate the highest standard of 'advice on standards of performance', but they will not hold any statutory standing.

2.19. We are clear that delivery bodies within health and care systems across the UK, including Boards and employers should not have a role in professional regulation, and would seek confirmation of this ahead of, or within, the Bill.

2.20. In introducing regulation of NHS and care managers and leaders, intentions will need to be presented ahead of or alongside the Bill itself on how dual registration of registered nursing staff in these roles will be managed, and aligned, as well as the devolved regulation of social care. This also presents the opportunity to address the regulation of wider nursing support workers, in addition to nursing associates in England. We note that introducing professional regulation for non-clinical roles require direct amendment to other legislation across the UK, or the creation of a new profession in the Bill.

2.21. On cost-effectiveness, we note that the full remit of the nursing regulator is funded through nursing registration fees, despite the limited contribution of the regulator currently to setting professional standards across the range of nursing roles and levels of expertise. The new powers should also seek to ensure fair funding mechanisms for public protection functions of professional regulators.

2.22. We are also aware of wider regulatory reform proposals which are in development. There will be benefits in being able to review all the related proposals together and provide a more comprehensive response.

2.23. *Discharge to assess*

2.24. In general, we are supportive of the 'discharge to assess' framework. There are many benefits for patients; having an assessment in their own home is likely to produce a more accurate picture of their

needs. We are however concerned about the current community workforce provision.

2.25. Since 2009, the number of FTE registered nurses working in the community has reduced by 4%. Numbers of district nurses have declined by over 40% in the last 11 years[5]. These trends could risk the safety of the implementation of the discharge to assess approach in practice. Without sufficient workforce provision to undertake assessment and respond to the identified needs, individuals could risk falling through the gaps. This could lead to people being at home without the support they need. Alternatively, it could lead to unsustainable workloads for community staff, which risks patient safety and outcomes.

2.26. Without sufficient workforce provision, we are concerned that this proposal could lead to increased readmissions and safety incidents. We are seeking assurance that there has been an impact assessment made of the readiness of the community nursing workforce to deliver these changes. The committee should consider whether it would be beneficial to include mandated timescales for assessments within legislation. This could have the benefit of triggering an intervention if the patient requires support when that time has elapsed.

2.27. This is also an opportunity for the government to provide additional funding for an increased number of places for community nursing roles, such as the district nursing qualification. Increased provision of district nurses would provide additional capacity and safeguards in the community to undertake assessments and provide people with support.

2.28. *Service reconfiguration*

2.29. Our members have highlighted some concerns about the proposed new power for the Secretary of State to intervene at any point within a service reconfiguration. Currently, decisions are made based on local insight, health expertise and considerations of safety and quality. This is undertaken in partnership with local decision makers and informed by engagement and consultation with local people.

2.30. We are concerned that this proposed power for the Secretary of State could potentially undermine local decision-making processes. This seems to be at odds with the direction of travel of the wider reforms which shift more focus towards collaboration of local decision makers for the benefit of local population.

[5] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/november-2020

2.31. Local authorities are already able to make referrals to the Secretary of State regarding service reconfigurations. We need to see further detail on the intended usage of this proposed power for the Secretary of State to directly intervene before we can fully support.

2.32. We are also responding to the NHSE/I consultation on the NHS Provider Selection Regime. In this, we set out our expectations for the considerations which commissioners need to make when procuring services. This includes assessing the impact on workforce, pay, terms and conditions, staffing levels and skill mix, and the patient pathway.

2.33. *Health Services Safety Investigations Body*

2.34. The RCN has long been supportive of the opportunity for HSSIB to provide a welcome shift from individual blame towards system learning when incidents occur. We believe one of the main drivers behind this culture change is the opportunity for staff members to reflect on situations within a 'safe space'. We recognise that there will be times when information shared within this space will need to be communicated to other bodies, for example if a staff member describes a crime they have committed.

2.35. It is important to ensure that the safe space is protected where possible, to retain the benefits for system learning that it provides. We would welcome further clarity on the intentions for the use of this power to expand the list of exceptions.

2.36. On a related note, this Bill affords an opportunity to provide a form of legal protection for nursing staff who deliver care in unsafe conditions, where they have raised/escalated concerns about safety. We will engage our members to develop further a proposal for inclusion within this legislation.

3. <u>The need for wider reform which is not covered by this white paper</u>

3.1. *Social care*

3.2. The government has been promising to bring forward proposals and reforms on social care for a number of years. It is disappointing that these have still not transpired, especially considering the current state of the social care system and the impact this has on individuals and their families.

3.3. The nursing workforce in social care has significantly declined in the last decade:

3.3.1. The latest data from Skills for Care [6](collected prior to the height of the pandemic), shows that there are currently an estimated 36,000 registered nurse jobs in adult social care. Most of these in care homes with nursing, in the independent sector (33,000).

3.3.2. The overall number of adult social care jobs increased by around 9% since 2012/13, and by around 1% between 2018/19 and 2019/20. However, registered nurses were one of the only jobs in adult social care to see a significant decrease; down 2,800 jobs (7%) between 2018/19 and 2019/20 and down 15,000 jobs (30%) since 2012/13.

3.3.3. In addition, the highest vacancy rate was for registered nurses at 12.3% (around 4,200 vacancies), up by 7.3 percentage points since 2021/13.

3.4. Workforce shortages create challenges for service provision and mean that individuals are less likely to have their needs met. In an integrated system, there must be stability in both the health side and the care. Without this, social care will continue to put an additional pressure onto health services when they are unable to meet the level of need and demand they are faced with. Social care reforms, along with additional funding must be in place before the implementation of the proposals set out in the white paper.

3.5. There are a number of areas which must be addressed within social care reforms for true integrated service planning and delivery:

3.5.1. Pay, terms and conditions: The RCN expects that nursing staff[1] working within social care settings should have competitive pay, terms and conditions with their colleagues with the same level of knowledge, skills and responsibility within the Agenda for Change structure.

3.5.2. Investment: Funding for social care should be sufficient to ensure staffing for safe and effective care in all settings, and to ensure all staff have access to fair pay, terms and conditions.

3.5.3. Workforce strategy: There should be a fully costed and fully funded workforce strategy covering all parts of the health and care workforce. The workforce strategy must include overall supply, as well as staffing levels, skill mix and professional education.

[6] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Workforce-estimates.aspx

3.5.4. Immigration: We are calling on the Government to make a route available for social care workers from overseas to be able to join the UK workforce. This could be undertaken through the development of an additional immigration route or amending the existing Tier 2 visa route.

3.5.5. Career progression: National bodies should investigate ways to introduce clearer career pathways to promote all nursing roles in the sector and/or promote movement between social care and the NHS (on a secondment / training arrangement).

3.6. We ask the committee to urge government to bring forward proposals for social care reform so that they can be assessed alongside the provisions set out in the white paper. This will allow for better identification of problems or gaps within futures structures and funding arrangements.

3.7. *Public health*

3.8. There are a number of proposals within the white paper focussed on public health. As the upcoming public health reforms having not yet been published, it is not possible to take an informed position on these changes.

3.9. The public health workforce in England is currently on the frontline of responding to the pandemic, and the timing of the restructure announcement is surprising. Our members are concerned that the reorganisation of public health functions is coming at a time when staff are overstretched dealing with COVID-19. It is also important to note that there have been years of insufficient investment and funding cuts to public health services. Government needs to ensure that staff are protected during the transition and are supported to maintain both pandemic and non-pandemic activities.

3.10. The future arrangements for PHE's other core functions and responsibilities, notably health improvement and prevention (which are stated UK Government priorities[7]), are yet to be confirmed. As the legislation set out the white paper progresses, it will be important for detail on the new public health structure to be published. These details must include the long term. sustainable and adequate resourcing needed for public health and investment and support for the public health nursing workforce to support the aims of integration and population

[7] Transcript of speech 'The future of public health' by the Secretary of State for Health and Social Care Published 18 August 2020
https://www.gov.uk/government/speeches/the-future-of-public-health

health. This will allow for scrutiny into the practical arrangements at ICS level.

3.11. Nursing plays a vital role in all areas of public health, and all nursing roles have public health responsibilities. Many nurses work in specialist public health roles such as school nurses, health visitors and occupational health nurses and across vital public health services such as smoking cessation, sexual and reproductive health, health protection, weight management, and addiction services.

3.12. Nursing staff have identified several themes which need to be addressed within the wider public health reforms.:

3.12.1. Fragmentation. There must be closer alignment between public health and the wider health and care system.

3.12.2. Funding. Reforms must put public health budgets on a sustainable level to meet the challenges within the population, secure staffing for safe and effective care and provide fair pay for all staff.

3.12.3. Leadership. Nursing roles are critical to identifying opportunities for tackling health inequalities and refocusing services towards prevention. Public health structures should embed nursing leaders at all levels of decision making.

3.13. We urge the committee to ask Government to bring forward their proposed changes for the public health system in England, so that they can be assessed alongside proposals relating to integrated care. The health and social care select committee should ask the government for further clarity on future funding arrangements for public health.

3.14. *Data and reporting*

3.15. There are several proposals relating to data and reporting within the white paper. We are supportive of these, and have a number of requirements for how data is captured and shared. Data reporting is critical to assessing the impact of the white paper proposals as they are legislated and implemented over the coming months and years.

3.16. Currently there is disparity between the national reporting of workforce data between independent (or local authority) and NHS providers, and also between the data collected at local level and that which is published nationally. This means that service and workforce planning cannot be credibly undertaken for the NHS or for the wider health and care system as a whole.

3.17. It is critical that all providers are required to allow their workforce data to be reported on publicly, not only NHS Trusts. This needs to include primary care and services which are commissioned by local authorities, including public health and social care providers. Reporting must include FTE numbers of staff by role and care setting, along with vacancy data. All providers should be required to collect and report on vacant posts, including a breakdown of how many posts are being filled by bank or agency staff. All workforce and vacancy data, for all providers should be made publicly available.

3.18. We also expect providers to collect, report on and publish data on the '9 safe nursing indicators' in order to generate a better picture of staffing and its impact on patient safety and outcomes.

3.19. Providers should also be required to produce and publish timely sickness data; currently available data is 4 months delayed. In a pandemic situation this does not allow for robust scrutiny into the impact of the pandemic upon staff members.

About the Royal College of Nursing

The RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

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