Royal College of Nursing Response to the Department of Health and Social Care's Major Conditions Strategy - call for evidence

About the Royal College of Nursing

With a membership of over half a million 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.

1. Introduction

1.1. The RCN welcomes the opportunity to respond to this call for evidence on the prevention, diagnosis, treatment and management of six major conditions groups that contribute to ill health in England. Nursing is at the heart of minimising illness. Nursing staff are embedded across the whole breadth of health and care settings and services and within communities, with unique expertise in the management of long-term conditions. As such, the nursing profession must be central to the design, implementation and oversight of the Major Conditions strategy.

1.2. We note, however, that previous commitments for single-condition strategies, for example on mental health, have been somewhat diluted into a 'catch all' strategy. It is essential for the public to have assurance that there will be safeguards in place to ensure that this dilution does not compromise the level of ambitious and scale of funding.

1.3. When announcing this strategy, the Secretary of State stated that these major conditions "account for around 60% of total Disability Adjusted Life Years in England"[i]. It is reasonable to expect that a significant proportion of the workforce be focused on interventions and support relating to these conditions. However, health and care services are currently not orientated towards this type of provision. There needs to be much more focus on supporting people to live well in the community, and for this to occur there must be substantial growth in the community nursing and public health workforce. This requires significant, additional investment following years of underinvestment and depletion.

1.4. Regarding this investment, we are concerned that significant proportions of the funding previously allocated to the NHS Long Term Plan delivery is at risk of being reallocated to the Major Conditions strategy. In reality, this risk could mean that services in England will not be able to meet the level of demand, risking needs being left unmet. This would be a poor use of public funding and should be avoided. Additional funding is also required to provide stability and growth within the nursing workforce. Continued workforce gaps will not provide

a secure foundation upon which to deliver the Major Conditions strategy and the NHS Long Term Plan.

2. Workforce context

2.1. The latest workforce statistics published by NHS Digital show that there are currently over 330,000 full time equivalent (FTE) nurses working in the NHS in England[ii] and over 16,500 FTE nurses working in General Practice in England[iii]. The nursing vacancy rates since 2017 have remained high. Latest data shows that there are over 40,000 nurse vacancies in the NHS in England[iv] and 4,900 nursing vacancies in adult social care[v].

2.2. Despite the nursing workforce growing, nurses within the community have been declining. Since September 2009, District nurses have declined by 44%, School nurses have declined by 31.8% and Health Visitors have declined by 29.8%[vi]. There are around 32,000 registered nurses currently employed in adult social care, which is down from 50,000 in 2012/13, a decrease of 36%[vii].

2.3. Adult social care is already over-stretched and underfunded, leaving needs unmet. If there aren't appropriate social care packages in place, then people fit to go home cannot be discharged from hospitals. This in turn means there are no spare beds so A&E patients cannot be admitted onto wards. A&E departments themselves fill up, so new people arriving must receive urgent care in inappropriate and often unsafe areas, such as corridors. This is evident in the data, the total size of the waiting list for planned care increased to 7.42 million in April 2023[viii], the highest number since data reporting began in 2007 and a growth of 170% when compared to the same period 10 years ago. Bed occupancy remains high, latest data shows 92.3% of General and Acute and 89.8% of mental health beds remained occupied[ix]. In May 2023, 23.2% of people attending A&E spent more than four hours from arrival to admission, transfer or discharge[x], and over 120,000 patients waited over 4 hours between the decision to be admitted and them being admitted[xi].

2.4. Macmillan found that nursing shortages have meant people diagnosed with cancer did not receive enough support from a specialist cancer nurse during their diagnosis or treatment. Almost half (44%) of their survey respondents said this led to them either ending up in A&E, being unsure of side-effects and being unsure if they were taking their medication correctly. Macmillan estimate that in 2030, there will be 3.3 million people living with Cancer in England and that if the number of specialist cancer nurses stays at its current level, there will be a shortage of 3,371 cancer nurses[xii].

2.5. General practice nursing provides a key role in both prevention and early detection. Challenges within general practice in the wake of the pandemic have prohibited nursing staff from undertaking the full range of their prevention and early intervention role. We are concerned that registered nurses are being

inappropriately substituted which risks the safety, effectiveness and outcome of the care being delivered. Nurse Specialists within the General Practice workforce have decreased by 17% and Practice Nurses have decreased by 1.7% since September 2015. Over one third (36%) of all General Practice nurses are aged 55 or over, and nearly one-fifth (18%) are aged 60 or over, therefore approaching retirement age.

2.6. To successfully design and deliver the Major Conditions strategy and the NHS Long Term Plan, we call upon the Government to deliver a fully funded government health and care workforce plan to ensure long-term nursing supply, retention and recruitment to meet the needs of the population. These plans should include specific measures on supply, recruitment, retention, and remuneration of nursing staff, both in the public and independent sectors, covering health and social care in all settings.

2.7. The Long-Term NHS Workforce Plan commissioned by UK Government has been produced, yet publication has been repeatedly delayed. The RCN expects this plan to be underpinned by an independently verifiable assessment of health and care nursing workforce requirements to meet the needs of the population and address health inequalities. Assessment of workforce requirements must reflect the RCN Nursing Workforce Standards and include an evaluation of health inequalities across geographies, services and settings, considering where health needs are greatest.

3. Improving patient outcomes

3.1. Nursing has a unique role in reducing health inequalities due to the access and interaction nurses have with individuals, families and communities throughout the life course. Nursing expertise can ensure that appropriate services are planned, designed, and commissioned equitably, to meet the needs of individuals and communities. Nurses should also be deployed as educators, advocates and activists, raising awareness of inequalities and driving action to address them.

3.2. Nursing leadership within Integrated Care Board membership is essential to ensuring that this focus on health inequalities is present in all commissioning decisions. It is important that all ICBs continue to include a registered nurse leader on their board.

3.3. Ensuring that health equity is a priority across government will necessitate training and knowledge-building for government departments and health equity impact assessments to be undertaken as part of policy development.

3.4. The development and expansion of new models of care for those with multiple conditions will go some way to help improve health outcomes. For example, the Virtual Ward model needs to shift away from a condition specific pathway to a range of conditions that is informed by the wider social care gap that impacts on people's lives and can be safely managed and cared for in the community.

However, to deliver the ambitions for any new model of care will require investment and sustainable funding that includes the skilled workforce required, now and in the future.

3.5. To improve health outcomes for people, there is an urgent need to address the nursing workforce and skills shortages, especially in primary care and community nursing. Since 2009, there has been a steady decline in the number of District nurses by approximately 5,000 to date[xiii]. This ongoing decline will have a significant impact on the ability to meet the NHS Long Term Plan ambition of providing care closer to home and meet the increasing acuity and complexity of patient needs.

3.6. Building a skilled workforce will require a greater level of investment in staff to not only ensure they are trained to the highest standard, but to also ensure that they are valued and have the right staffing levels and skill mix in place to care and support people with co-morbidities and their families. The development of a sustainable nursing workforce that is fit to deliver care, undertake and be able to action (including interpretation where required) a range of interventions will provide a positive contribution to the improvements in health outcomes. Many of these activities and responsibilities must be held by registered nurses who are appropriately trained to assess the needs and deliver the care and cannot be substituted by any other health professional. It is important that any expansion of the support workforce is undertaken alongside expansion of the registered nursing workforce to prevent inappropriate substitution.

3.7. We know that people with multiple conditions are more likely to be living in more deprived areas and that their clinical needs may be compounded by social factors[xiv]. For sustained improvements in health outcomes, it is important for the health care system to develop a more holistic approach to the interventions of care, which is patient-centred and responds to the needs of the whole person. To achieve improvements in health outcomes will also require cross government action to tackle the underlying causes of health conditions, along with investment in public services that affect people's health.

4. Supporting those with conditions

What impactful interventions can be adopted and scaled quickly? (In the next 1 to 2 years)

4.1. There are a number of opportunities which should be taken to better support those with conditions, these interventions include:

4.1.1. Targeted education and support to enable people to manage their health conditions more effectively and seek appropriate health care, needs to be consistently provided. The development of digital applications will further help to support people with monitoring as well as health information and literacy, to enable some ownership and control over their conditions.

4.1.2. Health checks/screenings would enable interventions to be made at an earlier stage to support more positive health outcomes. We know that

variations exist with the uptake of health checks in relation to socio-economic status, ethnicity and gender[xv]. The uptake of health checks may be more effective through primary care provision, given the trusting relationship that people generally have with their general practice and convenience in access. However, this will require further investment and expansion of the nursing workforce in primary care.

4.1.3. The management of people with co-morbidities needs to be considered in the context of a case managed hybrid approach, which utilises social prescribing and other initiatives not traditionally held within health portfolios. This might be particularly valuable, if properly resourced, as an intervention that has been shown to benefit improvements in patient outcomes.

4.1.4. To move away from short-term 'quick fixes', often linked with funding and political cycles, and move towards long-term, sustainable planning and investment into public health.

4.1.5. Primary and community care services are essential to the work of prevention and reducing health inequalities. There are excellent examples of nurse led models of care such as the management of long-term condition clinics, hospital admission avoidance, mental health in general practice and advanced practice. However, we have seen the adverse effects that the lack of funding and workforce planning has had across general practice and community settings. There needs to be an overarching national and sustainable approach to both the funding and roll out of prevention programmes and interventions.

How we can tackle disparities in health outcomes and experiences - including disparities that exist by gender, ethnicity, and geography. (Including building on the Women's Health Strategy for England and suggestions that can support improving men's health)

4.2. Health disparities are often linked to deprivation and socio-economic status; to specific protected characteristics including ethnicity and disability; to specific groups and/or to where people live. Inequalities stem from a range of complex factors and cannot just be simplified to individual responsibility.

4.3. Evidence shows that people living in deprived areas are more likely to live shorter lives, with additional time spent in ill health.[xvi] The COVID-19 pandemic brought these inequalities into sharp focus. The pandemic affected people and communities unevenly, with some population groups more vulnerable to infection, serious illness and death.[xvii]

4.4. During the first phase of the pandemic, in deprived areas of England and Wales death from COVID-19 was more than twice the rate of affluent areas.[xviii] Furthermore, mortality rates from COVID-19 in England have been higher among people of Black and Asian ethnicity than any other ethnic group.[xix]

4.5. Action to address health inequalities is not possible without strategic, demand-led workforce planning, based on assessment of population need and informed by data on health inequalities. Assessments of population demand must take into account the needs of more deprived areas and population groups where health needs are greater, with a key focus on ensuring that there are safe and effective accessible services available in those areas, which are able to meet the needs of the local population.

4.6. There is a need to focus on women and on men's health issues separately with focus a on specific health issues that disproportionately impact women (e.g. gynaecological issues, poverty, homelessness, violence, substance misuse, etc.) and men's health (e.g. cancers left undiagnosed, poverty, homelessness, substance misuse, etc.) separately, while recognising that issues such as poverty, homelessness, substance misuse, etc. affect men and women differently. There remains a need for awareness building and infrastructure to support transgender implications.

4.7. Government must action and build on the ambitions within The Women's Health Strategy[xx] including that policies and programmes for long-term health conditions and disabilities to consider women-specific issues by default, and take a life course approach to women's health, as well as considering wider determinants of health. The strategy also highlighted the ambitions around screening (e.g. cervical cancer screening) and a timely access to care for cancer to reduce risk, improve early diagnosis, and subsequent health outcomes and quality of life.

4.8. To drive this action, the RCN has called for some time for a cross-departmental national strategy for improving health and reducing health inequalities, including action to address the wider determinants of health.

How can we make better use of research, data and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions?

4.9. Improvements to the quality and availability of data is crucial to improving the outcomes for people with or at risk of major conditions, as well as collaborative approaches to sharing of data and best practices across trusts, organisations, charities and patient groups.

4.10. Improving access to linked data so that a complete picture of services is available and reported. This includes workforce data. Currently there is disparity between the national reporting of workforce data between independent (or local authority) and NHS providers, and 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.

4.11. There is also currently a variability in the level of seniority for nursing leadership within organisations regarding the digital agenda. These roles are important they can optimise the digital effectiveness of the workforce which can support reducing inequalities.

5. Tackling the risk factors for ill health

Do you have any suggestions on how we can support people to tackle these factors?

5.1. Yes

How can we support people to tackle these risk factors? (Please do not exceed 500 words)

5.2. The RCN has repeatedly raised concerns about the significant and widening gaps in the public health nursing workforce. In relation to key areas of public health, notably health visiting and school nursing, the RCN has highlighted concerns about funding cuts leading to services being decommissioned despite rising demand, and the resulting workload pressures affecting recruitment and retention, as well as concerning trends in skill substitution, for example in health visiting teams where checks are not consistently carried out by a qualified health visitor and regarding the declining provision and take up of specialist community public health nurse (SCPHN) training courses. [xxi] While the Institute of Health Visiting has highlighted that there are not enough health visitors to meet rising levels of need, and that children and families are experiencing a 'postcode lottery of support'.[xxii]

5.3. The strategy fails to mention that the workplace is a major factor where people (including health and social care workers) can develop Musculoskeletal (MSK) and mental Health (MH) conditions or have existing conditions exacerbated. Statistics produced by the Health and Safety Executive (2021/2022) show musculoskeletal disorder account for 27% of work-related ill health conditions; in the NHS, their 2022 employment survey shows 30.2% of respondents have an MSK.

5.4. Increased demands in the working environment, combined with staff shortages and unsuitable environments of care (e.g. corridors) could result in poor manual handling techniques being used and shortcuts being taken. Reducing the need for manual handling and the utilisation of correct manual handling aids, together with safe staffing, suitable training and supervision, would prevent and reduce incidences.

5.5. The workforce is getting older leading to increased vulnerability from MSK's if the risk from manual handling is not suitably controlled. MSK's can have a substantial and long-term effect on the individual, leading to increased

sickness absence, mental health being impacted and potentially having to cease work.

5.6. The HSE statistics for mental health conditions, including stress, depression or anxiety, account for 51% of work-related health conditions. The NHS 2022 staff survey demonstrates 44.8 % of staff have felt unwell due to work related stress, with 34% feeling burnt out because of their work.

5.7. Therefore, there is a strong case within this strategy for employers to ensure they are meeting their legal duty in doing all that is reasonably practicable to prevent the causes of work-related stress.

5.8. This includes assessing the risks to health and ensuring suitable control measures are in place together with supporting people at work through reasonable adjustments and time off to attend medical appointments for early interventions (e.g. physiotherapy and counselling).

5.9. Greater investment in, and ready access to multidisciplinary occupational health provision, and competent health and safety advice, for nursing staff working in the NHS and independent health and social care, would also support all the above. Early detection and advice through the general practice nurse to prevent sickness and loss of employment.

How can we improve access to palliative and end of life care?

5.10. From work undertaken by organisations such as the Nuffield Trust, we know that there are unacceptable variations in access to palliative and end of life care. There are also widespread geographical inequalities in the quality and type of care people (from different population, demographics and social-economic groups) receive. This is exacerbated by the shortages of specialist nurses and fragmentation of care.

5.11. More needs to be done to enable care to be delivered outside of the traditional hospital inpatient environment to support people if they wish to die at home. An increase in specialist community nursing skills is vital across all areas of community health care, not least those deployed across palliative and end of life care.

5.12. An increase in community-based provisions needs to be easier and widely available to improve access to care. To achieve this, it will require more joined up and collaborative working between services, and effective co-ordination of care.

The condition groups we are focusing on are often driven by preventable risk factors, with nearly half (42%) of ill health and early death being due to them. This includes tobacco, alcohol, physical activity and diet-related risk factors. Action on preventable

risk factors is also central to our work on tackling health disparities, since people living in more deprived areas are more likely to partake in these behaviours.

Do you have any suggestions on how we can support people to tackle these risk factors?

5.13. Yes

How can we support people to tackle these risk factors? (Please do not exceed 500 words)

5.14. The factors affecting people's health are complex and to tackle it there needs to be a whole-system approach, which looks more broadly at the wider determinants of health. This, of course, includes support from professionals to enable individuals to make healthy changes, however it is vital that the onus is not just placed on individuals.

5.15. Effective public health policy and targeted work with populations is essential to ensure that places and communities where individuals live are conducive to making healthy changes. There must also be adequate funding for public health to ensure local authorities have the resources they need to deliver vital public health services, for example services to help people quit smoking. Interventions should be co-produced with communities to ensure they are effective at overcoming barriers to access.

5.16. Funding for public health services and interventions in England has been subject to significant spending cuts, despite increased demand. The public health grant which funds local authorities to commission essential public health services has been cut by 24% on a real-terms per capita basis since 2015/16, with the cuts disproportionately affecting those living in the most deprived areas of England, who also tend to have poorer health.[xxiii] Without adequate and sustained investment in public health, the Government risks falling short of achieving its own ambitions including the levelling up mission to improve healthy life expectancy and reduce inequalities[xxiv] and the Sustainable Development Goals.[xxv]

5.17. Improving health and reducing health inequalities needs to be a cross government priority, with health recognised as an investment. There are significant gaps in the nursing workforce that is critical for addressing health inequalities. There must be a cross-departmental strategy for improving health and reducing health inequalities which includes action on the wider determinants of health, building on existing work and approaches that are already established for example Core20PLUS5.

5.18. Nursing is embedded across the whole breadth of health and care settings and services and within communities and has a unique understanding and perspective of public health which is critical for effective public health services. Nursing plays a vital role in all areas of public health: all nursing roles have public health responsibilities and opportunities to improve health.

5.19. The ongoing health and care workforce crisis is a major risk to the public health and prevention agenda, resulting in vital nursing roles being unfilled or in some cases unsuitably covered, services chronically understaffed, resulting in care left undone and undermining availability, quality, safety and effectiveness. Furthermore, staff shortages constrain the time, capacity and opportunities for nursing staff to deliver vital prevention and public health advice and interventions and/or undertake training and learning that will support and embed prevention more widely in their work.

6. Cardiovascular disease

In your opinion, which of these areas would you like to see prioritised for CVD? (Select up to 3)

Preventing the onset of CVD through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)

Stopping or delaying the progression of CVD through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)

Getting more people diagnosed quicker

Improving treatment provided by urgent and emergency care

Improving non-urgent and long-term treatment and care to support the management of CVD

How can we successfully identify, engage and treat groups at high risk of developing CVD through delivery of services that target clinical risk factors (atrial fibrillation, high blood pressure and high cholesterol)? (Please do not exceed 500 words)

6.1. Nursing staff in many areas of practice are key in helping to improve public understanding and in supporting the prevention of CVD. This focus is essential if we are to move towards the government objective of increasing healthy life expectancy by 2035 and additionally easing the pressure on the health system and reducing the number of people out of work due to ill health.

6.2. It is important to note that although secondary prevention is important (in this case the identification of clinical risk factors - atrial fibrillation, high blood pressure and high cholesterol), it is vital that we ensure that primary prevention is prioritised. CVD is largely preventable and the risk factors for CVD also apply to many other major conditions.

6.3. Targeted work must be undertaken with population groups, which are proven to have a higher incidence of the identified clinical risk factors. Interventions must be tailored to meet the needs of populations, based on understanding the barriers to an individual's diagnoses of the identified clinical risk factors. Co-production with communities is essential to overcome those barriers, including

building on existing work done at a local level to develop relationships with underserved communities.

6.4. It is also important to increase utilisation of existing resources and frameworks for healthcare professionals to facilitate behaviour change conversation, for example *All Our Health, OHID*[xxvi], and looking more broadly at the wider determinants of health. The factors affecting people's health are complex and to tackle it we need a whole-system approach. This, of course, includes support from professionals to enable individuals to make healthy changes, however it is vital that the onus is not just placed on individuals. Effective public health policy is essential to ensure that places and communities where individuals live are conducive to making healthy changes.

How can we better enable health and social care teams to deliver person-centred and joined-up services?

6.5. Building on the existing work done locally including sharing examples of best practice, targeted work with high-risk population groups, and shaping services to meet the needs of individuals.

6.6. This is not possible without investment in the skilled workforce required (now and in the future) and commission services that achieve the RCN's Nursing Workforce Standards[xxvii]. The RCN has been clear that the expertise of registered nurses is critical to the development of new models of care and the designing of innovative ways of working. Nursing staff have an important role leading service models and coordinating care at the interface between health and social care, managing the admission, stay and discharge of people accessing health services. They are clearly positioned to inform the much needed and long overdue modernisation agenda.

7. *Chronic respiratory diseases*

In your opinion, which of these areas would you like to see prioritised for CRD? (Select up to 3)

Preventing the onset of CRDs through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)
Stopping or delaying the progression of CRDs through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)
Getting more people diagnosed quicker
Improving treatment provided by urgent and emergency care
Improving non-urgent and long-term treatment and care to support the management of CRD

How can we better support local areas to diagnose more people at an earlier stage?

7.1. Targeted work with population groups who have a higher incidence and mortality of CRDs for example where we see higher incidence of smoking rates, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards.

7.2. Understanding barriers faced to accessing care and increasing education and awareness of early intervention. Co-production with communities to overcome those barriers and delivery of interventions that meets the needs of populations.

7.3. Investment in diagnostic pathways that meet the needs of populations. Community diagnostic hubs have been a good step forward. However, their funding for services provided and the skilled workforce required needs long-term funding. Much of this funding for development and ongoing provision has come from the NHS Long Term Plan in England.

7.4. Investment in the skilled workforce to ensure adequate capacity to identify risk factors and symptoms at the earliest possible stage. This includes general practice nursing as these nurses play a key role in both prevention and early detection. There is currently a trend to substitute these roles with other workforce and while in some cases they may be able to do a specific task they do not have the holistic nursing expertise required.

How can we better support and provide treatment for people after a diagnosis?

7.5. Investment in a skilled health and social care workforce to ensure there is adequate capacity to support long-term treatment and care in the management of CRD. Commission services that meet the RCN Nursing workforce standards.

7.6. There have been calls for the last decade to address the nursing workforce issues within specialisms such as respiratory and it is well documented that 50% of nurses are eligible to retire within the next few years[xxviii]. There needs to be an investment in recruitment and succession planning, this must include post-graduate education and across all settings including primary care.

7.7. People need to have equitable access and provision to services in their geographical area.

How can we better enable health and social care teams to deliver person-centred and joined-up services?

7.8. Building on the existing work done locally including sharing examples of best practice, targeted work with high-risk population groups, and shaping services to meet the needs of individuals.

7.9. Integrated care boards should be empowered to develop services across organisations including workforce flexibility built into contracts e.g., integrated posts.

8. *Dementia*

In your opinion, which of these areas would you like to see prioritised for dementia? (Select up to 3)

Preventing the onset of dementia through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)

Delaying the progression of dementia through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)
Getting more people diagnosed quicker
Improving treatment provided by urgent and emergency care
Improving non-urgent and long-term treatment and care to support the management of dementia

How can we better support local areas to diagnose more people at an earlier stage?

8.1. Timely diagnosis influences treatment options which can slow down the disease progression in dementia. It also gives professionals the opportunity to identify and plan for future need such as access to antibiotics to prevent unnecessary emergency admissions, the development of hospital passports or the 'This is Me'[xxix] document to support emergency admissions and the development of advanced care plans. A project in Norfolk shortlisted for an RCNi award has developed a care home team of nurse specialists to provide diagnosis and treatment plans for people living in care homes. This project has resulted in an increase in diagnoses of dementia and subsequent treatment plans and has now been extended to a 14-area pilot scheme which could end up a national initiative.

8.2. The World Health Organisation predicts that 5-8% of people over the age of 60 have dementia, however as many as 50% of people with dementia will remain undiagnosed due to stigma associated with the condition. The development of increased clinics to support diagnosis[xxx], including nurse-led memory impairment and advisory teams, utilise hybrid working to deliver face to face and virtual assessments aimed at securing earlier diagnosis. Early assessment and treatment can slow rate of deterioration and support maintenance of quality of life and independence.[xxxi] Nurse-led clinics provide a range of benefits for the patients as nurses deliver holistic assessments, care plans, interventions, and analysis which accompanies the patient journey providing evidence-based person-led care alongside compassionate leadership and coaching for the patient and their family at point of diagnosis.

8.3. There are a number of initiatives aimed at supporting early diagnosis and treatment, utilising nurse practitioner roles to lead clinics[xxxii] these clinics can support effective assessment and planning for newly diagnosed people.

8.4. The implementation of care home teams for diagnosis and training – improving diagnosis rates, dementia assessment teams within social care nursing and support with care planning post-diagnosis[xxxiii]. During the pandemic there was a drop in diagnosis of dementia for people living in care homes and this not only impacts on the person themselves, but their carers and other people within the home; a diagnosis would change access to support services.

How can we better support and provide treatment for people after a diagnosis?

8.5. People with dementia can receive treatment to minimise the symptoms of dementia and potentially slow down the deterioration of the condition. The use of specialist nurses who can prescribe and plan care play a vital role in this area of dementia care. It is well evidenced that people with dementia are more likely

to have difficulty managing other health needs which can lead to avoidable hospital admission, therefore delaying the progression of dementia through medication, talking therapy and other health-led initiatives can be of benefit to the wider health economy[xxxiv]. Delaying the progression of dementia supports maintenance of independence and less reliance on multiple services.

8.6. System wide support groups which build on existing community support groups such as Dementia UK[xxxv] there needs to be a combination of face to face and online options to meet as much need as possible. The commissioning of these services needs to consider voluntary, community and social enterprises to maximise availability of service provision and reduce health inequalities. There may also be existing groups which can provide the services required.

8.7. Increase the use of technology is essential. There are free applications for exercises, mood monitoring, mindfulness, and many other self-help apps. These can be accessed at any time and from the privacy of the person's own home. There are also several initiatives to support older people getting online which can reduce isolation and enable virtual networking and meetings[xxxvi].

8.8. There is a lot of evidence about diagnostic overshadowing in the learning-disabled community but this also transcends to people with dementia, which can result in poorer physical health outcomes. Reversible conditions are left untreated as they are deemed to be part of the dementia progression[xxxvii].

How can we better enable health and social care teams to deliver person-centred and joined-up services?

8.9. Awareness of local/regional demography and how this will impact on service requirements and service delivery – for example in certain areas where there have been successful initiatives to reduce hypertension there may be a correlating reduction in vascular dementia. There are known health inequalities in poorer areas which also need consideration when planning and delivering services.

8.10. Scope the existing local services across ICSs and consider feasibility of replicating across systems – many projects such as Enhanced Care of Older People (EnCOP) are working well in local areas and could become national initiatives[xxxviii]. In addition to the framework EnCOP also provides professional networking meetings and webinars to share innovation and good practice.

8.11. Specialist commissioning for dementia services nationally to work across health and social care using links and statute from the Health and Care Bill for ICB and ICP joint working.

8.12. Endorsement of existing dementia groups – support national development and public awareness. The decommissioning of the National Dementia Action Alliance has left a number of local dementia action alliance (LDAA) groups who are continuing to work towards dementia friendly

communities' endorsement of these groups[xxxix] and communities will strengthen them[xl].

8.13. Health promotion activities such as walk and talk groups and singing for breathing to support healthy lifestyle choices[xli] the use of effective health promotion or primary prevention will reduce the requirement for secondary prevention and interventions. This could reduce the growing number of people living with dementia in the future, but it must be acknowledged this is a long-term strategy. However, the use of positive health promotion specifically impacts on people with dementia who are often living with multiple long-term conditions which need careful management and reduction interventions.

9. *Musculoskeletal conditions*

In your opinion, which of these areas would you like to see prioritised for MSK? (Select up to 3)

Preventing the onset of MSK through population-wide action on risk factors and wider influences on health, often referred to as primary prevention.
Stopping or delaying the progression of MSK through clinical interventions for individuals at high risk, referred to as secondary prevention.
Early diagnosis of MSK to reduce long-term effects and speed up recovery
Improving treatment provided by urgent and emergency care
Improving non-urgent and long-term treatment and care to support the management of MSK

How can we better support local areas to diagnose more people at an earlier stage?

9.1. Ensure nurses and other members of the primary care team receive training on diagnosis, early treatment and when to refer as they are the first point of contact for patients with MSK symptoms. This will reduce the number of patients attending A&E because they have not received treatment.

9.2. Enabling prompt diagnosis and onward referral to secondary care to mitigate delays to treatment.
9.3. Access to MSK specialists in primary care to speed up early diagnosis and treatment, reducing the need for further interventions through secondary care in the future.
9.4. The widening of referral routes should be reviewed, to improve capacity issues affecting patient access to primary care and thereby improving timely diagnosis, this includes inclusive language as the referrer is often a nurse rather than a general practitioner.

How can we better support and provide treatment for people after a diagnosis?

9.5. Training, development and retention of Senior Nurses including nurses working at an advanced level (experienced and skilled general practice nurses and Advanced Nurse Practitioners) in these areas of specialist practice to provide patients with ongoing support throughout their care continuum.

9.6. Reduce new to follow up ratios in secondary care and upskill the workforce to support their care e.g. Blood Monitoring, prescriptions, lifestyle management, exercise plans, etc.

How can we better enable health and social care teams to deliver person-centred and joined-up services?

9.7. Regular multidisciplinary meetings to share best practice, develop treatment plans and reduce referral on to secondary care and A&E.

9.8. A joined-up IT system is imperative for 'joined up' care. Primary care, secondary care, pharmacists, other AHPS should all be able to access patient records to enable agile working, to be responsive and avoid unnecessary delays to patient care.

10. Cancer

How can we better support those with cancer? (Please do not exceed 500 words)

10.1. Primary Care

10.1.1. The UK Government should facilitate stronger coordination and oversight of primary care workforce distribution in England - taking into account GPs, community pharmacy, district nursing and roles supported by the ARRS (Additional role reimbursement scheme) – to tackle regional disparities in workforce density.

10.1.2. NHS England must closely evaluate the effectiveness of interventions to widen cancer referral routes through community pharmacy to understand how far it can improve capacity issues affecting patient access to primary care and improve cancer diagnosis.

10.1.3. The Primary Care recovery plan[xlii] has eroded the role of the nurse in general practice. The report does not recognise the extensive knowledge and assessment skills of the nurse, the second largest staff group in primary care. Care provided in general practice is broken down into tasks, no longer looking at the patient holistically. The RCN believes this is a safety critical issue, increasing the risk of missed diagnoses. To make general practice an employer of choice, recruitment and development plans are urgently needed. This includes equal pay terms and conditions to their NHS employed colleagues and financial support to train nurses to be general practice nurses, a skilled and diverse role.

10.2. Variation in the workforce

10.2.1. NHS England must evaluate the effectiveness of new routes into medicine, and the impact these can have on addressing regional inequalities. These data should feed into decisions on the distribution of funding for new medical school and apprenticeship places.

10.2.2. The UK Government should conduct a regional review of clinical research activity. The review's findings should inform proposals for additional

funding that facilitates increased research engagement within regions currently under-served by research. The review's findings should also inform revisions to existing R&D investment, with a view to making this investment more regionally equitable and unlocking research capacity.

10.2.3. UK Government and Devolved Administrations should invest more in under-served specialties and engage with networks (e.g. ICSs) to identify opportunities to unlock research capacity.

10.3. Skill mix

10.3.1. Health education providers across the UK should design training courses flexibly to maximise their availability. This may include e-learning or modular courses that reduce the geographical and financial barriers to participation.

10.3.2. Local and national health leaders must secure buy-in from the health workforce as they drive the implementation of skill-mix approaches. This includes carving out time for training and development, embedding it into local and regional workforce plans and sharing examples of best practice.

10.3.3. Skill mix must not be to the detriment of patient care, who deserve to have a holistic approach to their care with minimal contacts.

10.4. Preparing the workforce for the future

10.4.1. The strategy must consider the future of cancer care, such as the genomics workforce in their 10- and 15-year projects, making fully funded commitments to growing this workforce.

10.4.2. Health education organisations should ensure that all new medical and nursing graduates have a good awareness and knowledge of genomics, and that the healthcare science workforce receive iterative advanced genomics training and education.

How can we better support local areas to diagnose more people at an earlier stage?

10.5. Although early diagnosis is important, it is vital we ensure that primary prevention is prioritised. More than 4 in 10 UK cancer cases could be prevented largely through lifestyle changes[xliii]. Targeted work with population groups, that evidence proves, have a higher incidence of ill health and early death in relation to cancer. Co-production with these communities is vital to overcome those barriers and design interventions that meets the needs of hard-to-reach groups.

10.6. Strategies for raising public awareness will require a co-ordinated approach to information campaigns on prevention and detection at a national, regional and local level. The messaging and method of delivery will be important to connect with the diverse population so that it is accessible, particularly for those most at risk.

10.7. Better use of local diagnostic hubs and appropriate staffing, together with joined up reporting and IT systems so information can be accessed by all professionals involved in their care from any location. This would expedite delays, enhance communication between all parties and ensure that onward referrals and referral to treatment targets are delivered.

10.8. Better local, community knowledge, networking and education would help people recognise early signs and symptoms of cancer and encourage them to go to their General Practice to be reviewed. Early warning signs should be triaged appropriately and reviewed regularly.

10.9. The widening of cancer referral routes should be reviewed to improve capacity issues affecting patient access to primary care and thereby improving timely cancer diagnosis.

10.10. Improving health and reducing health inequalities needs to be a cross government priority, with health recognised as an investment. There are significant gaps in the nursing workforce that is critical for addressing health inequalities. There must be a cross-departmental strategy for improving health and reducing health inequalities which includes action on the wider determinants of health.

How can we better support and provide treatment for people after a diagnosis?

10.11. Improvements in the after care and support to cancer patients and their family will require the availability of an appropriately trained workforce. If the ambition of a world class cancer service is to be achieved, which includes the support required after diagnosis, significant investment will be required to shape the long-term vision and plan for cancer care.

10.12. Staff retention and appropriate skill mix can enhance patient care after diagnosis. Experienced Nurses, Doctors, AHPs undertaking patient education, support, counselling and navigating their care pathways takes time, skill and experience. Keeping experience within the workforce supports training of junior staff to deliver the same level of care for future generations.

10.13. Investment in learning, development and education opportunities for the cancer nursing workforce is required for all levels of practitioners in specialist cancer roles/services. The RCN Career and Education Framework for Cancer Nursing (2021) provides a framework through which this can be done to help bring consistency of knowledge, skills and career progress of cancer nursing.

11. Mental health

How can we better support those with mental ill health? (Please do not exceed 500 words)

11.1. Across the UK there have been a range of political and policy commitments to achieve parity of esteem for those with the most serious mental health problems. This aspiration draws on a range of factors, including the knowledge that those with mental health problems like schizophrenia and bipolar disorder die between 15-20 years before the general population[xliv].

11.2. It is the RCN's view that holistic care is vital, and mental health needs cannot be separated from that which relate to physical and social needs. RCN members have suggested there is risk in over-emphasising the need for 'more counselling and brief talking therapy,' without parallel and sufficient investment in services that can help to ensure parity of esteem is realised. It is the RCN's view that all

people, including the most marginalised groups in society, benefit from a holistic approach to support wellbeing[xlv], where a 'one-size approach' does not and will not work[xlvi].

11.3. The holistic practitioner role of the nurse is central in bringing the public health lens of mental, physical and social wellbeing into fruition. Registered nurses can help people to understand the difference between our wellbeing and a severe and enduring mental illness. In this sense, helping to address the over-pathologizing of people's natural responses to challenging issues (i.e. stress and moral distress)[xlvii].

11.4. The wellbeing of the population is intertwined with issues of inequalities and marginalisation, with the impact of inequalities such as 'income' being shown to correlate with health and wellbeing[xlviii]. In the current context, with a cost-of-living crisis, priority must be given to reducing the financial hardship experienced by people with low incomes and/or high debt, including many nurses across the UK[xlix].

11.5. If the Government is to address the issues of mental wellbeing for the population, health and care policy must acknowledge that many people become acutely or chronically distressed through a combination of bio, psycho and social factors that are not best thought of as within their control.

How can we better support local areas to diagnose more people at an earlier stage?

11.6. It is important that early diagnosis and intervention in mental health care becomes a goal across all elements of healthcare. However, psychiatry is not an exact science and diagnoses may change over time depending on presentation.

11.7. Where mental health issues are becoming more prevalent across the country, RCN members are concerned with the risk of over-medicalising people's experiences. The RCN holds the view that it is vital that the UK population understands the difference between mental wellbeing (staying mentally well), psychosocial stress (natural response to life-challenging issues) and mental illness (debilitating condition that may limit someone from undertaking their day-to-day activities).

11.8. The RCN would like to highlight the issue of understanding mental health and early intervention across the lifespan: a significant proportion of people who experience mental health problems, have experienced trauma in childhood and may continue to experience trauma as a result of discrimination or exclusion on the ground of race, disability or other characteristics.

11.9. The RCN calls for more investment into early intervention and psychological support in schools and in communities: helping people to resolve difficult emotions and to cope at difficult points in their life in a more responsive way, which avoids them reaching 'crisis point'.

How can we better support and provide treatment for people after a diagnosis?

11.10. The RCN continues to call for further funding of statutory mental health services in registered nurses practice including within primary care.

11.11. To prevent long-term mental illness, RCN members are calling for increased financial investment with a focus on robust community support services to prevent hospital admissions and long-term residential placements which can deskill the person.

11.12. 'Widening choice' is understood as a necessary step to improve the mental wellbeing of many people who do not respond well to the limited available first-line treatments.

11.13. RCN members suggest that for some people these prescribed interventions do not work, we should be giving them different options for resolving their difficulties - instead, we label people as 'treatment resistant' or 'chronic' suggesting that the individual is at fault. Rather than acknowledging the limitations of the current offering of treatment that is available in the UK.

11.14. In the context of 'widening choice,' the RCN continues to advocate for a move towards co-production between people with lived experience of mental illness and use of services, with policy makers, professionals and system leaders: we cannot hope to learn from our mistakes without listening to those affected.

11.15. RCN members suggest that mental health Trusts need to stop using risk as a barometer for service provision and access. RCN members are clear that in their experience, some acute inpatient mental health units only accept admission of people detained under the Mental Health Act or at very high levels of risk to themselves and/or others. Gatekeeping to treatment based on risk and capacity alone, does not support early diagnosis, intervention or the prevention of deterioration.

11.16. Mental health nurses in primary care can support distressed and 'at risk' patients at the first point of contact without passing people onto different providers. In turn, reducing pressure on secondary services and reducing unnecessary delays in accessing care and treatment.

11.17. There is increasing concern that registered nursing is becoming diluted across mental health services[l]. The role of registered mental health nurses must not be substituted by an unregistered workforce for the purpose of meeting workforce targets or creating cost savings. The public must always have access to the right support, in the right place and at the right time, centred around patient safety and professional accountability.

11.18. Any health and care workforce strategy must take specific steps to ensure that increases in the overall nursing supply result in an expansion in the numbers of nursing staff working in mental health settings and includes a fair pay rise for all nursing staff. The RCN is clear that any strategy must be based on an independently verified assessment of population and workforce needs.

11.19. Education and continued professional development are central to safe and effective staffing. Nursing staff working in mental health should be supported through fair workplace procedures, as well as access to clinical supervision, continuing professional development (CPD) and opportunities for career progression, to ensure they can provide the best care and treatment.

How can we better enable health and social care teams to deliver person-centred and joined-up services?

11.20. Although ICS models are inclusive of health, social care and independent sectors, members report the need to improve early intervention by tapping into spiritual lead[er]s in the communities, such as Imams and Pastors; central community resource and gateway for many.

11.21. One approach in addressing and understanding individual needs is to: work to embed trauma informed practices; a move away from diagnostic led treatment pathways, to formulation informed care.

11.22. The RCN continues to call for an assessment of the capacity and structure of crisis and community-based mental health services for people with complex emotional needs (i.e., people with a diagnosis of personality disorder)[li]. Services must align with the four areas of the Mental Health Crisis Care Concordat, which are:

- access to support before crisis point;
- urgent and emergency access to crisis care;
- quality of treatment and care when in crisis;
- recovery and staying well.

11.23. It is vital that clinical leaders and organisational managers acknowledge their role in supporting, challenging, and reviewing the practices and services within their organisations. Accountability must be clear at all levels. This responsibility must not lie solely on practitioners and emergency workers who are constrained by governance and commission parameters.

11.24. In the context of providing care to people in a crisis, the RCN advocates for the development of a joined-up approach to crisis care: including improved integration, information sharing and better communication between services (such as police, ambulance, A&E, mental health teams and support services).

11.25. Suggested solutions include having a joint-services approach to creating a shared database with all relevant information which is simple to access and

upload live information. However, such a move will need to consider and overcome potential data protection issues[lii].

11.26. The RCN would like to emphasise the current system pressures faced by secondary mental health services and the wider-public sector: people are under so much pressure, that they try to pass actions to other teams and this should always be a team approach.

11.27. Within this context, the RCN recommends that all services who respond to people in mental health crisis must have shared policy and protocols that set out clear service parameters around roles and responsibilities. Such a move is understood as providing benefit in developing collective responsibility and avoiding the blame game.

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June 2023

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