Royal College of Nursing response to
Department of Health and Social Care consultation on
health and social care statistical outputs published by DHSC (including OHID), NHSBSA, UKHSA, ONS and NHS England

General feedback on health and social care statistics

Question 1: How do you find the process of finding the health and social care statistics that you need?

Answer: Difficult.

The fragmented nature of the health and social care system in England is reflected in the current statistical landscape. Health and social care data are produced, gathered, processed and communicated by different organisations and in very different formats. In some cases, these organisations all produce statistics on the same topic. This adds another layer of complexity to those entities that use health and care statistics to monitor and evaluate the state of the health and care system and its preparedness to withstand future challenges.

For instance, statistics on COVID-19 infections in the community can be found on the ONS website and via the UK Health Security Agency. The NHS has also a dedicated monthly page reporting on the number of patients admitted with confirmed COVID-19. Assessing whether the number of people in the community with COVID-19 is putting pressure on the NHS, requires accessing statistics from different bodies and in different formats.

Similarly, statistics on adult social care are produced by NHS England, the Department of Health and Social Care, and the Office for National Statistics. They cover different aspects of adult social care and come in different formats (e.g. Excel files, surveys, and interactive charts and visualisations). This lack of a coherent approach to data management has an impact on the RCN ability to not only monitor and evaluate the state of adult social care in England but also produce data-driven recommendations.

A data repository built around a standardised approach to data gathering, management and presentation could address these issues. Instead of having different bodies producing statistics around a singular issue, efforts could be made to streamline the statistics to present a coherent and accurate picture of the system and support the formulation of sound, evidence-led policy recommendations.

Another area that could greatly improve the quality of the insights (including usefulness) that we can produce from the outputs published by the bodies forming this consultation is the timeliness of the publications. For example, workforce statistics are released monthly and vacancy data quarterly but both with a three-month lag. Sickness absence rates are four months old by the time they are published. In general, data collected as a 'snapshot' is months out of date. This impacts our ability to have a clear picture of workforce pressures and their impact on service delivery.

Such a repository or data hub should allow data users to access accurate, timely and, if possible, in a standardised format, data covering different aspects of the health and

social care system that put together can show a clear picture of its current state and the potential challenges that can threaten its long-term sustainability.

Question 2: **Statistics can be presented in different formats. If you have any feedback on the format that health and social care data and statistics are provided in, please provide it here.**

We will welcome the standardisation of formats used across the different bodies that are part of the consultation. Currently, the data is presented in a variety of formats depending on the organisation. For instance, most of the NHS data comes in XML and CSV with formats that sometimes cannot be pivoted or reformatted to obtain timely insights.

Similarly, the UK Health Security Agency recently launched a data dashboard that shows data on respiratory viruses in England. Although visually attractive and relatively easy to navigate, its interface is not interactive, and the underlying data supporting the charts are not available unless downloaded in a CSV or JSON format. The static dashboard does not allow the user to, for instance, produce time-series analyses of the number of COVID-19 cases against the number of deaths without the user having to download both files (infections and deaths) separately, formatting the data and conducting the analysis themselves. The accessibility of the data for those with limited technical skills is severely restricted.

Recently, the NHS has begun to introduce interactive dashboards that allow users of all abilities to obtain the insights they need. We welcome this development. However, access to the raw data underpinning the dashboards or pivot tables is important because this enables us to design and build our own data analytics infrastructure to run the data processes needed to obtain the insights that we consider relevant to the monitoring and advocacy work of the RCN.

Question 3: ONS, DHSC, NHS England and UKHSA are all exploring the proposal to publish a higher proportion of outputs in a dashboard or interactive tool format. To what extent do you agree or disagree with this proposal?

Answer: Strongly agree.

The RCN supports this proposal. This approach will make all the available data accessible to all users, irrespective of their ability to manipulate and analyse data.

However, all the outputs produced in a dashboard or interactive format should be accompanied by the raw data files to allow more in-depth analysis if needed. Alongside this, we would like to see documentation that clearly explains where and how the data was sourced, a data glossary or metadata repository, and any data caveats and limitations that might impact the accuracy and robustness of insights produced by external users.

Question 4: ONS, DHSC and NHS England are all exploring the proposal to:

- *reduce the level of detailed commentary provided alongside statistical outputs*
- *reduce how frequently commentary is provided alongside statistical outputs.*

To what extent do you agree or disagree with this proposal?

Answer: Disagree.

The detailed commentary provided alongside the statistical outputs is fundamental to ensure that users understand the nature of the statistics and the conclusions that can be drawn from them. It also provides information on the quality and reliability of the data and clarifies complex terminology. This prevents the data being misinterpreted or any insights produced being inaccurate or misleading.

Question 5: Given the complexities of data collection, validation and analysis in health and social care statistics, it is not always possible to prioritise all of the following quality dimensions:

- *relevance of health and social care statistics to meet user needs in terms of content and coverage*
- *accuracy and reliability: how close the estimated result in health and social care statistics is to the true result*
- *timeliness and punctuality of health and social care statistics*
- *accessibility and clarity of health and social care statistics - including quality of metadata and accompanying advice, accessible data sets and visual content*
- *coherence and comparability of health and social care statistics over time and geography (as health and social care is devolved, coherence of statistics across the UK can be challenging. Where statistics are not comparable, explanations of different methodologies are recommended)*
- *availability of health and social care data at local level geographies.*

Please add any comments about which of these quality dimensions should be prioritised.

Accuracy and reliability should be prioritised so that data can be used with confidence and any analytics can be trusted. Timeliness and punctuality of health and social care statistics are fundamental to ensure that any insights derived from the data apply to the present or as close to it as possible. Insights resulting from outdated data are of little use when the aim is to respond to issues and challenges as they arise.

The availability of health and social care data at local levels is urgently required because this represents the comparability of health and social care statistics over time and geography. Currently, it is almost impossible to provide detailed analyses of NHS data on health and social care that go beyond the national, regional or integrated system

level (ICS; health geography) against population health needs data collected at district or county levels (administrative geography).

For instance, most population health data is gathered and reported at the county or district levels (administrative geography), but the nursing workforce data responsible for ensuring better health outcomes comes at the NHS Trust level (health geography). Both geographies have different boundaries that overlap in some cases.

Finally, as mentioned, any future outputs must be accompanied by a description of metadata and accompanying statistical commentary to ensure the validity of any derived interpretation of the data. To make all the statistics accessible to the public, the RCN will welcome investment in developing the technical infrastructure and harmonisation of the data gathering and management process so that the data is shared using interactive dashboards that help translate complex data into meaningful insights with minimum manipulation.

Feedback on statistical topic areas

Adult Social Care

Please explain which statistics you use on this topic area and summarise how you use them. And describe what changes to statistics on this topic area might be beneficial for you in the future and why?

Registered nurses play an important role in adult social care nursing. The RCN continues to monitor the number of registered nurses working in this sector, as the numbers of registered nurses in social care have plummeted over the last decade. This poses particular challenges to integrated care structures as gaps in social care services negatively impact the local provision of health services.

We would like to see data on demand for services, outcomes for people using current services, and projections for likely future needs. This will enable better long-term workforce planning, resourcing and funding decision-making.

For adult social care, the workforce data must be more reliable from a nursing perspective. This is not currently the case, as it depends on employers completing the Skills for Care's Adult Social Care Workforce Data Set (ASC-WDS). We would welcome the introduction of robust and compulsory workforce data reporting across all providers and presented at national, regional, and ICS levels, as well as the publication of raw data for interrogation, as currently Skills for Care only publishes detailed estimates once a year.

Data on the field of nursing registered nurses working on adult social care services and what level of practice they are employed at would also help us to have a clear understanding of the adult social care nursing workforce and enable us to identify gaps against population needs.

This will enable us to monitor trends in the number and composition of the nursing workforce in social care, recruitment and retention indicators, and vacancy reporting across different providers. This would also enable relevant bodies to assess the progress/success of new Integrated Care Systems (ICS), including whether providers have the means and workforce for safe and effective care and whether care across all sectors is joined up in a way that leads to the best outcomes for people using services.

If you have any feedback on statistical products not covered elsewhere, please outline it here.

We constantly monitor the NHS workforce data to understand nursing workforce trends and their impact on service delivery. We identify some gaps in the data provision that, if addressed, could provide a clearer picture of nursing workforce trajectories within the NHS.

First, we would like a breakdown of the workforce statistics by registered nurses and health visitors. Currently, within the Excel files released with the monthly work statistics, the England-level file provides a comprehensive breakdown of the nursing workforce by Nurses in HCHS and GP settings (excluding Health Visitors), HCHS Nurses (excluding Health Visitors) and Nurses in General Practice. We would like the same approach replicated across the different workforce datasets focusing on nursing.

In addition, we would like to see nursing workforce statistics provided at the National, Regional, ICS and NHS Trust levels in the same data package. This data is currently available across different Excel files that require a certain level of manipulation.

We would like to see the introduction of data from NHS Digital on the length of time registered nurses spend working for the NHS before leaving. Furthermore, data on Reasons for leaving and staff movements by staff group is not available and has to be requested directly from NHS Digital. This could help us identify at which stage registered nurses are more likely to leave the service and develop recommendations to address these reasons. Furthermore, to understand the impact of workforce pressures on the nursing workforce, we welcome the introduction of sickness absence data broken down by organisation, ICS, reason and staff group.

At the RCN, we want to monitor how workforce pressures impact different population groups. We welcome the introduction of more granular details on the nursing workforce's demographic characteristics. This helps us greatly to explore, for instance, which population groups are more likely not to show career progression or are more affected by disciplinary proceedings.

Furthermore, data related to leavers and joiners is currently provided in the NHS Digital/England HCHS staff turnover in two different datasets, one quarterly ('HCHS staff in NHS Trusts and core organisations month year - turnover tables') and the other one monthly ('turnover from organisation benchmarking tool, month year'). Despite looking at the same data, it is somehow confusing that they show different turnover figures without this discrepancy being clearly explained in the notes accompanying the publication. This limits their use as it reduces user confidence in interpreting the data.

Similarly, the nursing workforce vacancy data is a great concern for the RCN as it indicates workforce pressures and their impact on patient safety. We would welcome monthly reporting rather than the quarterly output that is currently provided. Moreover, as the vacancy statistics produced by the NHS are 'experimental in mature', we welcome introducing a definite methodological approach to collecting vacancy statistics. This should be accompanied by detailed information on the sources, methodology, and limitations. Currently, the RCN is not confident that the experimental nature of these statistics provides a factual description of the reality.

Finally, in the NHS survey, staff should treat registered nurses, health visitors and midwives separately. Workforce categories should be standardised across all data related to the nursing workforce.