Royal College of Nursing
England

Staffing for safe and effective care:

an opportunity to change the law now

RCN MEMBER BRIEFING

What's the issue?

Earlier this year, the RCN welcomed the *Long Term Plan for the NHS* in England. This plan sets out an ambitious direction for health and care services in England, with an emphasis on prevention and shifting care into the community. The main NHS agencies, NHS England (NHSE) and NHS Improvement (NHSI), have since set out proposals for legislation changes to help the NHS to deliver the plan. Most of these focus on supporting integration and collaboration between health and care services, giving more power to local leaders. NHSE and NHSI are consulting the public on these proposals until 25 April 2019.

The RCN will respond to the consultation and individuals are also encouraged to do so. Our top priority is to ensure that changes to the legislation include clear accountability for workforce. Clear legal duties for workforce must be set out for Government, commissioners, providers, and the new integrated structures.

The RCN welcomes proposals enabling local decision-makers to come together more easily to provide joined-up services for local populations. The nursing profession works across organisational boundaries and sectors (for example, public health, health and social care), so we are well aware of the benefits of enabling integration. However, we are seeking assurances on aspects which require appropriate safeguards or frameworks to ensure good standards of integrated service design and workforce planning.

We are continuing to consult with our members and staff across England to test this initial position, and to further develop positions on each of the other proposals.

Opportunity for staffing for safe and effective care

The proposed legislation update provides an ideal opportunity to introduce clarity on roles, responsibilities and accountabilities related to staffing for safe and effective care. Without these elements being addressed, it is likely that the nursing workforce crisis will continue to develop without clear recourse to hold Government and other bodies to account for the provision of sufficient nursing workforce to deliver safe and effective care. Existing workforce gaps will continue to negatively impact upon patient care and safety without intervention.

Currently, existing policy levers, including the powers of Secretary of State for Health and Care, and duties assigned to organisations, do not clearly set out responsibilities for workforce strategy, planning and development.

At every level of decision making about the health and social care workforce, from Government level to local provider, any determination about nurse staffing must be informed by legislation, Nursing and Midwifery Council requirements, national regional and local policy, research evidence, professional guidance, patient numbers, complexity and acuity, the care environment and professional judgement. Financial resources and expenditure must be in place to fully fund and support the delivery of workforce plans and the provision of nurse staffing for safe and effective care.

The RCN is clear that this opportunity must be taken to address the existing lack of clarity with regards to responsibilities for workforce, which has contributed to the existing and widely recognised crisis.

How can members get involved?

You can respond to the consultation with a template letter focused on our staffing for safe and effective care accountability asks, by visiting this page: https://www.rcn.org.uk/news-and-events/news/act-now-to-help-halt-workforce-crisis.

You can also make a full response on the consultation hub here: https://www.rcn.org.uk/get-involved/consultations/con-3219, or by emailing consultations@rcn.org.uk. To support you in responding to the consultation, we have set out our priorities and positions within this briefing document.

What are the proposals?

i. Shifting from competition to collaboration

To support the NHS to become more integrated, NHSE/I are proposing that the Competition and Market Authority (CMA) would no longer have powers to review mergers involving NHS Foundation Trusts. Alongside this, NHS Improvement would no longer be required to apply UK and EU competition law to health services.

This would allow the NHS to make decisions about mergers, rather than an external body overseeing them. In practice, this could mean that decisions can be more focused on benefits for patients, and progress towards integration, rather than promoting or protecting competition.

Emerging position: We welcome these proposals, and have some confidence in the safeguards set out. We are continuing to consult with our members and staff across England to test this initial position.

ii. Getting better value for the NHS

Commissioners and providers have expressed frustration with the amount of time and resource spent awarding or bidding for contracts. NHSE/I have proposed that the regulations which require this procurement process to be in place should be removed.

This proposal would make it easier for commissioners to use their discretion when awarding contracts, with decisions based on a 'best value test' rather than a lengthy procurement process.

Emerging position: We welcome this proposal and believe that it would reduce lengthy and costly bureaucracy. However, further clarity is needed on the 'best value test'. Alongside the elements set out in the proposals, we recommend that the 'best value test' also includes specific consideration of (1) the likely impact on the workforce, and on any recruitment or retention strategies which are underway; (2) the delivery of high-quality nursing practice, and in the delivery of safe and effective care; and (3) active consideration of relevant issues in making any decisions, with explicit regard to local population need and workforce issues.

Our recommendation is that guidance should be based upon a nationally agreed 'best value' framework, and that a clear mechanism is developed to assess the impact of this. Development of 'best value' approaches should involve clinical and patient groups, and take into account the current evidence base, as well as wider systemic issues and priorities.

iii. Increasing the flexibility of national NHS payment systems

At the moment, payments made to providers for assessing and treating patients are decided nationally, and this is the price which CCGs will pay to providers. NHSE/I are proposing that this is changed to allow national prices to be set as a formula rather than a fixed value, so that the price payable can reflect local factors.

This would allow more opportunities for collaborative working between providers and commissioners to design and agree how they approach prices for treatments at a local level.

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Emerging position: We welcome this proposal based on its intention to provide greater flexibility to reflect local factors, and to support better flow through care pathways. We are mindful that current payment systems can act as a disincentive to early intervention and timely discharge from acute settings. However, we are looking to gain assurance about the consultation which will take place locally, to make sure that decisions about payment involve all the necessary decision-makers and evidence.

iv. Integrating care provision

Last year, the NHS introduced the Integrated Care Provider contract. This allows a provider to deliver a number of services under one contract, with a combined budget. In practice, this supports the delivery of integrated care, however CCGs have reported it being challenging to identify appropriate providers to hold this type of contract. To address this barrier, NHSE/I are proposing that law should be clarified so that the Secretary of State can set up new NHS trusts to deliver integrated care across a given area.

Emerging position: The formation of more Integrated Care Providers could lead to potential changes for staff who may have to work across sectors or across different settings. These changes could offer welcome opportunities, such as more autonomous working. However, if financial considerations and cost-saving measures are prioritised, the introduction of providers who have a greater remit, could result in unsafe nurse and nursing staff levels and skill mix, unless matched with greater transparency and scrutiny.

Integrated Care Providers should therefore only be formed if it can be demonstrated that there will not be an adverse effect on the pay, terms and conditions of any staff involved, and that their plans promote patient safety and effective care.

We also seek reassurance that increased deployment of the Integrated Care Provider contract will not lead to a diminishment of the nursing voice or leadership role within services, as they come together under one contract.

v. Managing the NHS's resources better

To facilitate integration, there is a proposal that NHS Improvement has targeted powers to direct mergers or acquisitions involving NHS foundation trusts. This power could only be deployed in specific circumstances, where there are clear patient benefits. They would also be able to set annual capital spending limits for NHS foundation trusts, in the same way that it can currently do for NHS trusts.

Emerging position: Further clarity is needed as to how patient benefits would be quantified and measured. This should be expanded to take into consideration the wider contextual factors involved in mergers, such as the impact upon nursing staff, pay, terms and conditions, and upon ongoing recruitment and retention strategies.

vi. Every part of the NHS working together

Rather than establishing Integrated Care Systems (ICS) as new bodies, which would require lots of legal changes to the powers and responsibilities of CCGs and trusts, NHSE/I are proposing changes which would allow CCGs and trusts to work together as ICSs.

In practice this would give CCGs and trusts the ability to create joint committees, and they could delegate decision-making powers to these committees. Alongside this, NHSE/I are proposing a removal of restrictions which currently prevent nurses and doctors working for local providers from being able to be appointed to CCG governing bodies. Currently, an individual would be appointed to a CCG out of area.

Emerging position: We recommend that these committees be given specific functions or remits related to assessing local population needs, workforce planning and contributing towards the delivery of a national workforce strategy.

vii. Shared responsibility for the NHS

NHSE/I are proposing that a new shared duty should be introduced that requires CCGs and NHS providers of care to promote the 'triple aim'. This shared 'triple aim' would be: better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS. In practice, this would mean that CCGs and providers would be focussed on working towards the same ambitions, meaning there would be more opportunities for alignment and close working.

Emerging position: We welcome the introduction of a shared duty. We consider this an ideal opportunity to include a specific duty for these organisation related to the workforce, through expansion of the proposed duty.

viii. Planning our services together

The proposal is that groups of CCGs be given the ability to collaborate to arrange services for their combined populations. Alongside this, groups of CCGs would be able to use joint powers and lead commissioner arrangements to make decisions and pool funds across all their functions.

This would allow CCGs to make joint decisions with other CCGs, and would therefore aid integration. There would also be opportunities for CCGs to become more involved in the decisions about specialised commissioning. At the moment, CCGs may commission part of a pathway and NHS England would commission a further part for those with specific complications or who need additional support. These proposals would allow closer working between CCGs and NHS England.

Emerging position: We welcome this proposal, and recommend that these arrangements also be expanded. There should be explicit duties for CCGs entering into joint arrangements to understand local needs and plan workforce to meet this need, and this requires local collaboration. They should be responsible for escalating concerns about workforce and data gaps into the system. They also need responsibilities for delivering clear objectives as part of national workforce strategy. With these responsibilities, they should be accountable for enabling providers to deliver services with the workforce they need to ensure safe and effective care.

ix. Joined-up national leadership

At national level, the proposal is being made that NHS England and NHS Improvement be brought together more closely, either by creating a single organisation or being provided with more flexibility to work together. Alongside this, there is a proposal that the Secretary of State be given powers to transfer functions between Arm's Length Bodies (ALBs), or to create new functions for them.

The result of this could be the organisation responsible for setting the direction of the NHS and ensuring effective patient care could be merged with the organisation tasked with delivering financial sustainability and efficiency within the NHS.

Emerging position: The RCN broadly supports the proposals. Expanding powers for the Secretary of State for Health and Social Care provides a clear opportunity to articulate the new duties for workforce that we have called to be included in this legislation. The existing mechanisms have proven not to be sufficient for the Secretary of State to direct the system with regard to workforce.

We note that there could be potential for conflict of responsibilities within lead national NHS organisations, specifically between system financial pressures and efficiency, and meeting a comprehensive service to meet the health needs of the population. It will be important to understand and gain assurance on the mechanism for transparent decision making and resolution in these types of conflict.

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