

# Response to NHS England and NHS Improvement on Implementing The NHS Long Term Plan

Proposals for possible changes to legislation



In early 2019, the NHS Long Term Plan was published. This plan described the ambitions for the NHS over the next decade. NHS England and NHS Improvement subsequently set out proposals for changes to legislation to help the NHS to deliver the plan. Most of these proposals focussed on supporting integration and collaboration, giving more power to local leaders. This paper was written in response to the engagement opportunity which NHS England and NHS Improvement held in relation to the legislative proposals.

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Published by the Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN

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## 1.0. OVERVIEW

- 1.1. We broadly welcome these proposals for the stated intentions to enable greater integration and collaboration to meet the needs of the population, and to deliver *The NHS Long Term Plan* in England.
- 1.2. Alongside the proposed structural changes, meeting these intentions will also require robust, transparent mechanisms for finance and service planning and delivering quality services, nationally and locally. Workforce planning is a core component of service design and planning.
- 1.3. However, across the health and care system and at the various levels within this system, there is currently a lack of explicit clarity on roles, responsibilities and accountabilities related to the workforce. This has resulted in fragmented and incomplete approaches and workforce planning is often missing from wider strategies. Without clarity, services cannot be delivered safely or effectively. Although there is a need to embed culture change towards meaningful, credible and data-driven workforce planning within the system, there is a critical and urgent need to clarify roles and responsibilities.
- 1.4. This proposed update to legislation provides the ideal opportunity to explicitly set out roles, responsibilities and accountabilities related to staffing for safe and effective care across the system. Without this, it is likely that the nursing workforce crisis – and indeed across a range of professional groups - will continue to develop without clear action to enable sufficient workforce and without recourse to hold Government and the range of national, regional and local bodies to account for the supply, recruitment, retention and remuneration required to deliver safe and effective care. Without intervention, existing workforce gaps will continue to negatively impact upon patient safety, care and outcomes.
- 1.5. The health and care service is currently being compromised due to insufficient numbers of staff. Introducing a clear legal framework for accountability would not further compromise the service, but would instead support the system to resolve these workforce issues.
- 1.6. Any expanded powers and autonomy for national, regional and local decision-makers must be balanced with greater accountability and transparency. This must be set out within a national accountability framework for workforce, codified in legislation. A comprehensive legal framework will also address accountability for resolving national issues which cannot be resolved by sub-national structures such as Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), or locally by commissioners or providers.
- 1.7. Workforce accountabilities within Government and across health and care system bodies must therefore be supported by a robust legal framework. This will aid the integration of responsibilities into wider duties related to finance and service planning and quality service provision in an explicit way, rather than continuing to accept the level of risk that is inherent with the current implicit and unclear approach. Taking action in this way will also provide a mechanism for holding all parts of the system to account for delivery of defined responsibilities and functions.
- 1.8. We call for a complete legal framework, supported by additional relevant policy and funding levers, which addresses the following five aspects of workforce:
  - 1.8.1 **Clear accountability** - Specific duties for Government, national bodies, commissioners and providers to make sure there are enough registered nurses and nursing support staff, and other professional groups, to meet patients' needs.
  - 1.8.2 **Right numbers and skills** - Decisions regarding staffing levels for safe and effective care should be based on assessment of local needs, evidence, workforce planning tools, and the professional judgement of senior clinicians.
  - 1.8.3 **Workforce strategy** - A credible, fully funded strategy for tackling registered nurse and nursing support staff shortages and those in other professions, to meet the whole country's health and care needs.
  - 1.8.4 **Transparent planning** - Quality assurance of workforce planning

within the system for the right numbers and skill mix of registered nurses and nursing support staff, alongside other parts of the workforce to deliver safe and effective services.

**1.8.4 Education** - Government enabling education of enough nursing students, as well as investing in learning and development for existing staff, to equip the nursing workforce to meet patients' needs.

- 1.9. We note that the Royal College of Physicians stated in their response to the Health and Social Care Select Committee inquiry on the NHS legislative proposals that there should be 'a specific duty for the Secretary of State for Health and Social Care to ensure that there is sufficient workforce to meet the needs of the population within health and care services, accompanied by clear roles and responsibilities for NHS arms-length bodies to enable a funded workforce strategy'. We welcome this position.
- 1.10. We also note that the Royal College of Psychiatrists stated in their response to the Health and Social Care Select Committee inquiry that they "support the proposal by the Royal College of Nursing to give greater legal clarity on where responsibility lies for ensuring the NHS has the workforce it needs". We welcome this position.
- 1.11. Other stakeholders also recognise that the current structure for managing the supply of staff is not fit for purpose. The National Audit Office (NAO) <sup>1</sup> have described it as 'fragmented' and warn that the approach risks incoherence. Their report describes that this fragmentation means national bodies do not have either the information they need to make decisions, or the power to implement them. The NAO sets out that national bodies are reliant upon coordinated efforts with those who have different priorities from them; so in reality there is no coordination.
- 1.12. In response to the specific proposals put forward by NHS England and NHS Improvement, we welcome the intention to enable local decision-makers to come together more easily in providing joined-up services for local populations. Nursing is a profession which routinely 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 seek additional assurances, further to what is set out within proposals, on aspects which require appropriate safeguards or frameworks to ensure good standards of integrated service design and finance and workforce planning. We address these additional requirements alongside each proposal.

- 1.13. We consider the following proposals to have the greatest implications for workforce planning, and for which we seek particular assurances. These are; *getting better value for the NHS, integrating care provision* and *every part of the NHS working together*.
- 1.14. We have developed this position through consultation and engagement with members and staff across England, and with stakeholders including professional bodies, trade unions and patient groups. We have also supported our members to directly respond to the engagement opportunity, and at the point of submitting our organisational response around 10,000 of our members have done this. Our dual role as a professional body and a trade union ensures that our priorities reflect both professional nursing practice and employment issues.

## 2.0. ACCOUNTABILITY FOR WORKFORCE

- 2.1. The ultimate aim in clarifying accountability for workforce is to ensure all health and care services are of high quality, and equipped to provide safe and effective care for patient safety, experience and outcomes.
- 2.2. Our members are clear that this opportunity must be taken to address the existing legal and functional ambiguity with regards to workforce which has contributed to the existing and widely recognised crisis. Taking this positive action will allow for workforce planning to be integrated within wider service planning, with the specific focus required to ensure that services can be of high quality.
- 2.3. Existing levers, including the legal powers of the Secretary of State for Health and Social Care, and legal duties assigned to organisations, do not currently clearly set

- out responsibilities for workforce strategy, planning and development which are sufficiently explicit and aligned with each of their roles and functions.
- 2.4. At every level of decision-making about the health and social care workforce, from Government through to any local provider, any determination about registered nurse and nursing support 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.
  - 2.5. 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. These requirements should be applied to workforce specifically, and then embedded into broader decision-making on service planning at national, regional and local levels. The current approach does not identify workforce requirements proactively, but allocates resources based on what remains when other decisions have been taken.
  - 2.6. This requirement has already been identified in different forms by devolved administrations in Wales and Scotland. In Northern Ireland progress has been challenging due to a lack of Government, however the Delivering Care policy sets out guidance for commissioners in relation to nurse staffing. The approach taken in Delivering Care focuses on the role of professional judgement. This advocates an evidence-based approach in response to local need. In England, devolved and fragmented structures of the commissioning, funding and delivery of health and care services create much room for ambiguity which is reflected in the actions of national and local players across health and care.
  - 2.7. All decisions regarding staffing for safe and effective care, from national bodies through to local organisations, should be based on assessment of patient and population need, up-to-date evidence base, workforce planning tools, and the professional judgement of senior nurses. Health and care services should be understood and promoted as a safety critical industry, and the adequate provision of staffing recognised as a critical requirement for the delivery of safe and effective models of care.
- Current system – fragmentation and a lack of clarity**
- 2.8. The Secretary of State for Health and Social Care currently has a broad, existing duty to promote a comprehensive health service<sup>2</sup>. This may be understood to implicitly include accountability for workforce supply, but is clearly open to interpretation. There is no specific legal duty for the Secretary for State to ensure that there is sufficient workforce to meet the needs of the population within health and care services, including taking appropriate action on supply, recruitment, retention and remuneration. This duty must be explicit and specific to workforce supply, so that it cannot deprioritised without recourse.
  - 2.9. The power to issue an annual mandate to the NHS is limited to setting objectives for the current functions of NHS England. As NHS England does not have any explicit legal duties related to the workforce, they would not be mandated to undertake objectives within this area. The legislative proposals do not address this. While it may be possible, in theory, for Government to address workforce shortages via service commissioning channels, this is tenuous, open to interpretation and to date has resulted in insufficient action which has not resolved the historical boom and bust approach that has been taken to these issues which fundamentally negatively impact on patient safety, experience and outcomes. This particular ambiguity has played out consistently over time.
  - 2.10. This ambiguity has also been demonstrated through the development of the recent *NHS Long Term Plan*, necessitating the Government to commission a system-led national workforce group to analyse the issues, and make recommendations back to Government. While we have welcomed this action, as a means of beginning to address these fundamental issues, we consider the development of an NHS delivery plan, which is fundamentally dependent on the securing of additional funding from Treasury, to be a demonstration that the

- current legal framework for accountability is not effective.
- 2.11. The development of *The NHS Long Term Plan* provides an example of the ambiguity and conflicting expectations playing out in practice. In her speech in June 2018, the Prime Minister, Theresa May, said “Growing demand and increasing complexity have led to a shortfall in staff. So, our ten-year plan for the NHS must include a comprehensive plan for its workforce to ensure we have the right staff, in the right settings, and with the right skills to deliver world class care”. The Secretary of State for Health and Social Care also committed that *The NHS Long Term Plan* would address workforce supply issues. On publication, NHS England acknowledged the significant workforce supply issues, but confirmed that these requirements are additional to the service planning aligned with the existing financial settlement for the NHS. There is no guarantee that these services can be delivered safely or effectively to meet the growing health and care needs, and little accountability or recourse available.
  - 2.12. A lack of accountability and responsibility for sufficient workforce has also led to an incomplete understanding of credible levels of funding needed for supply. This means it is not considered appropriately in budgetary decisions. Workforce requirements for the long term must be properly assessed and funding requirements properly considered. These decisions should be based on evidence, demand and need. A failure to do this should not then result in attempts at trade-offs from within previously agreed health and care budgets, which we believe to be happening now as a result of workforce planning run separately from national health and care service planning. Investment in health and care workforce should be recognised and understood as fundamental to the delivery of service, with requirements baked in from the outset. Going forwards, the legal framework needs to support the system in securing adequate funding to deliver the comprehensive health and care service including robustly assessed workforce requirements.
  - 2.13. Without clear national leadership, there has not been a credible conversation with the public about the need for additional investment in the health and care system in order to provide sufficient numbers of staff to deliver services safely and effectively. There are opportunities for this to be a positive conversation and opportunity; investing in the health and care workforce is key to keeping the population well and unlocking national productivity. This leads to a good return on investment.
  - 2.14. There is a plethora of evidence linking staffing levels with service quality, safety and outcomes. Therefore, investment in the workforce is key to delivering quality services, and without it there are costs which arise. The World Bank<sup>3</sup> sets this out clearly, stating that delivering care which is not of sufficient quality contributes to both the global disease burden and leads to unmet health needs. They identify that a lack of investment ‘exerts a substantial economic impact’ both in terms of lost productivity and in terms of correcting preventable complications of care and harm. It would be appropriate and reasonable for this to be the starting position of any decisions being considered by Government.
  - 2.15. Recent court cases have also highlighted the breadth and lack of specificity in regard to the Secretary of State’s duties related to the health service. A prominent example of the need for greater clarity regarding the Minister’s responsibilities was the legal dispute between junior doctors in England and the Secretary of State regarding the introduction of new NHS contractual arrangements in 2016. In relation to the Secretary of State’s duty to ‘promote a comprehensive health service’ (NHS Act 2006) the Judicial ruling stated that “it is difficult to contemplate a broader target duty”.
  - 2.16. Furthermore, this ruling highlighted that the Secretary of State’s duty to protect the public (NHS Act 2006) is framed in terms of a broad objective of “protecting public health” and is a duty only to take the “steps” which the Secretary of State considered appropriate, thereby leaving “considerable leeway to the Minister as to ways and means.”
  - 2.17. This conclusion clearly supports the position that a lack of specific duties at this level gives too much room for interpretation in prioritising, or

- deprioritising, workforce requirements.
- 2.18. Health Education England (HEE) is often referenced as the national body within the system responsible for workforce. HEE has some legal responsibilities, but they are not currently supported through sufficient legal powers to take action or invest to increase the national supply of registered nurses and nursing support staff, or other professional groups in order to meet the needs of the population within health and care services. HEE is therefore, unfortunately, limited to developing solutions within available resource which is clearly insufficient to meet need.
- 2.19. The only explicit legal reference to the requirement for sufficient numbers of staff is contained within the Health and Social Care Act Regulations, where the deployment of sufficient “suitably qualified, competent, skilled and experienced persons” is listed as a requirement condition for providers to fulfil their regulated activities duties. This duty is also set out within the NHS Standard Contract, meaning that the mechanism for holding providers to account is through contracts, rather than through a legal framework. It is our position that these duties (and others as described below) must be set out in law.
- 2.20. This issue is further complicated by the fact that providers have no power to increase the national workforce supply. Many are struggling to secure, supply and recruit, remunerate and retain staff, without a credible national strategy in place which fully addresses these aspects. While local decision-makers may be held to account for local decisions on staffing for the provision of safe and effective services, they are unable to resolve national workforce shortages nor could it credibly be considered their responsibility.
- 2.21. In practice, the lack of clarity in terms of national accountability by Government and agencies means that workforce policy and funding decisions have become reactive, rather than proactive, and solutions are limited and piecemeal. Rather than the establishment of safe and effective models of care, followed by funding, the financial envelope is determining how the health and care transformation is translated into action. This has led to a situation in which the

system currently defaults to discussing how to ‘fix the workforce gap’ (100,000 vacant posts including 40,000 nurses). However, the overall size of the workforce is not based on an assessment of changing needs, and as such there can be no assurance that filling this gap would even be sufficient.

- 2.22. This has come about in part due to the lack of clear accountability for doing this. The crisis would not have come about to this extent if we had been able to hold individuals and organisations to account for clear responsibilities, and if everyone’s roles were clear in relationship to supply, recruitment, retention and remuneration.

### **Introducing additional duties and accountability for workforce**

- 2.23. We call for organisations to be granted the specific duties and legal powers to deliver relevant workforce contributions aligned with their role and function. Within Government, the Secretary of State for Health and Social Care should be explicitly accountable for the provision of workforce. Each player throughout the health and care system then needs a clearly defined role commensurate to the level and complexity of their responsibilities, so that they can be clear about their functional role in delivering sufficient registered nurses and nursing support staff, and other professions to meet population need, and ensuring those registered nurses and nursing support staff, and other professional groups are in the right place at the right time to deliver safe and effective care.

### **Government duties**

- 2.24. The Secretary of State for Health and Social Care should be accountable to Parliament for ensuring an adequate supply of staff to provide safe and effective care, with regard for the wider workforce needs across all publicly funded and commissioned health and social care. This duty should include accountability for ensuring a fully costed and funded national workforce strategy, based on the assessed needs of the population. This duty would help to prevent further workforce supply and development problems now and in the future.

### Duties for NHS arms-length bodies

- 2.25. National bodies such as NHS England, NHS Improvement and Health Education England (HEE), should hold clearly defined powers and duties related to the workforce, specific to their wider service and finance planning and delivery roles and responsibilities. For NHS England and NHS Improvement, this should include specific duties for workforce planning, and supporting the system to implement plans. For HEE, this should include a duty and specific functional powers to enable quality of education and training, supported by funding to deliver the level of provision set out by the Secretary of State for Health and Social Care and within a national workforce strategy.

### Responsibilities for Integrated Care Systems

- 2.26. Integrated Care Systems (ICS) provide a good opportunity for supporting and coordinating integrated service planning and should include workforce planning. They are well placed to understand local population need, understand the relevant workforce requirements, and communicate this to national bodies. This needs to be undertaken with sufficient levels of transparency and accountability.

### Duties for Clinical Commissioning Groups (CCGs)

- 2.27. Commissioners should have a legal duty to understand local needs and plan services and workforce to meet this need. They should have responsibilities for delivering clear objectives as part of national workforce strategy. They should be accountable for enabling providers to deliver safe and effective services, and for escalating concerns about workforce and data gaps into the national system. Although local authority commissioning is outside the scope of these proposals, we believe it necessary for these duties to also be in place to ensure that the health and care workforce receives the same level of priority, regardless of the commissioning arrangements.

### Provider duties

- 2.28. Providers, who are also employers, of publicly funded health and social care

services (regardless of sector) should be held accountable for demonstrating their corporate accountability for decisions on workforce planning to deliver safe and effective services, underpinned by evidence. These decisions should ensure that vacant posts are recruited to, and that shifts are staffed according to patient need and acuity. Providers should be required to regularly publicly report on staffing levels and skill mix for the range of services they provide. Alongside this, there should be mechanisms for transparency within their decision-making to allow for robust scrutiny.

## CONCLUSION

- 2.29. If all of these legal responsibilities were in place, within a complete legal framework, we believe that it is more likely that the health and care system would be much better equipped to work together to plan how the workforce can be grown and developed to deliver a comprehensive, quality care service to meet the needs of the population. Without these changes, the workforce crisis is likely to continue, with patients facing greater risk to their safety, experiences and outcomes.
- 2.30. It is clear that the ambitions of *The NHS Long Term Plan* can be supported to be realised in part by resolving now who must be accountable and responsible for the actions we have described. It is critically important that Government and each player in the health and care system is fully clear on their workforce-related duties and accountability so that all can be confident about meeting the health and care needs of the population, now and in the future.
- 2.31. All of these positions are directly drawn from the RCN's UK principles for legislation for staffing for safe and effective care, published in *Staffing for Safe and Effective Care: Nursing on the Brink*, published in May 2018<sup>4</sup>.

## 3.0. RESPONSE TO THE SPECIFICS SET OUT WITHIN PROPOSALS

- 3.1. The proposals set out by NHS England and NHS Improvement describe intentions which we welcome in principle. However,



- they require either expanding to include specific workforce duties, or the provision of further assurances to mitigate against unintended consequences.
- 3.2. *Shifting from competition to collaboration: This is the proposal that mergers involving NHS Foundation Trusts would no longer be overseen by the Competitions and Market Authority (CMA).*
- 3.3. We welcome the intention of these proposals, and anticipate that the role of NHS Improvement in this process will be sufficient, whilst avoiding expense and bureaucracy. Given the impact that these changes could have upon the registered nurse and nursing support staff workforce, we believe it is necessary for registered nurses and nursing support to be consulted on the development of plans. This is especially important if any local merger leads to a situation in which there are requirements for staff to move across multiple sites, or across a larger footprint.
- 3.4. *Getting better value for the NHS: This is the proposal that existing procurement regulations be revoked and replaced with a 'best value test'.*
- 3.5. We welcome the intention of this proposal and believe that it would reduce lengthy and costly bureaucracy. However, further clarity and detail is needed on the 'best value test'. Alongside the component parts set out in the proposals, we seek assurance that the 'best value test' includes specific consideration of whether NHS Commissioners are obtaining best value from their resources in terms of:
- active consideration of relevant issues in making any decisions, with explicit regard to local population needs, patient outcomes and workforce issues;
  - the delivery of high-quality nursing practice, and in the delivery of safe and effective care;
  - patient choice and patient safety;
  - the likely impact on the workforce and their training and development requirements, and on any recruitment or retention strategies which are underway.
- 3.6. Our recommendation is that implementation and guidance should be based upon a nationally agreed and evidence-based 'best value' framework, and that a clear mechanism is developed to assess the impact of this. We recommend that a nationally-agreed 'best value framework' should be commissioned to support these proposals. This framework should include the requirement that short, medium and long-term workforce plans are developed, with phasing to demonstrate how this would be implemented. 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.
- 3.7. In terms of developing this framework, we have previously created assessment criteria for the workforce elements of service redesign or change<sup>5</sup>. These questions may provide a useful starting point for the framework:
- Is there a clear workforce plan – and has this been integrated with financial and activity plans?
  - Is the proposal making most effective use of the workforce for service delivery and is it compliant with all appropriate guidance?
  - Has the proposal considered any training and development needs for the existing workforce to meet the proposed service delivery?
  - Is there any consideration for implications for future workforce?
  - Have staff been properly engaged in developing the proposed change?
  - Is there evidence of staff consultation and analysis of risks and mitigation actions?
- 3.8. Senior registered nurses have described trends in which contracts tend to be awarded to 'the cheapest' service provider, rather than necessarily the one which will provide the most comprehensive care. It is important for legislators to consider what type of national mechanism should be in place to provide independent scrutiny over the decision-making process based on quality and patient outcomes. This should include clear safeguards to ensure that procurement does not allow services to provide remuneration below Agenda for Change structures, which should serve as a minimum pay offer.
- 3.9. Our members have already highlighted previous 'best value' approaches to

- procurement, which should be learned from in developing a new version. In particular, members have brought attention to the Local Government Act 1999, which set out conditions for local authorities to make decisions based on an assessment of best value. The Audit Commission provided oversight for the initial implementation of this approach. However, members have raised that since the dissolution of that body, many local authorities shifted away from attempts to comply with their duties in this way.
- 3.10. Given this example, it would be prudent to hold the implementation of this proposed best value test ‘under review’. This would give regular opportunities to assess the impact of the test upon decisions. This would allow for data trends to be monitored, particularly patient outcomes. The review mechanism should include clear opportunities for relevant parties, including providers, staff representative groups and the public to raise concerns, and for these to be taken into account. These reports should be appropriately responded to locally, and collated nationally and made public, so that policy makers can identify themes within the concerns raised, and consider any necessary systemic response.
- 3.11. Our members have also pointed to examples where contracts have been awarded to providers without relevant clinical expertise, for example the Health Visiting and School Nursing service in Slough<sup>6</sup>, which was awarded to a smoking cessation provider. Concerns have also been raised that this aspect of the legislative proposal, combined with the creation of joint provider and commissioner committees, may undermine truly independent assessment of ‘best value’. It is critical that the best value test includes safeguards to ensure that providers are able to demonstrate sufficient expertise in delivering the required services, and in managing clinical risk, and that concerns can be raised and independent scrutiny provided.
- 3.12. These safeguards may include:
- Setting minimum standards for key conditions.
  - Ensuring appropriate expert clinical input to decision making.
  - Ensuring effective consultation with both patient groups and advocates for vulnerable patient groups including children; patients with learning disabilities and the elderly.
- 3.13. *Increasing the flexibility of national NHS payment systems: This is the proposal that national tariff prices be set as a formula rather than a fixed value.*
- 3.14. 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.
- 3.15. *Integrating care provision: This is the proposal that the Secretary of State would be able to set up new NHS Trusts to deliver integrated care (‘Integrated Care Providers’ where one contract is used for multiple services together).*
- 3.16. We have consistently been supportive of the stated aims and underpinning objectives of sustainability and transformation initiatives across the health and social care system in England but we have previously raised concerns about how this has been applied in practice. Given the potential impact of integration on the delivery of safe and effective care, scrutiny and assurance is required at every stage. Any changes which could lead to negative impacts on patient safety, outcomes or experience must be avoided.
- 3.17. An Integrated Care Provider (ICP) is an organisation which holds a single contract for multiple services. The aim of this is to give one lead provider responsibility for the integration of services for the local population, specifically to enable integration of primary medical services with other health and care services.
- 3.18. The formation of ICPs could potentially lead to changes for staff in terms of working across sectors or across different settings. These changes could offer welcome opportunities, such as more autonomous working. However, the introduction of providers who have a broader remit could result in the prioritisation of financial efficiencies, rather than quality, across services. Unchecked, this could result in poor workforce planning to ensure the right people, with the right skills, are in the right places to meet the needs of patients. This in turn could further result in unsafe staffing levels and skills distribution to

- provide the care patients need.
- 3.19. Therefore, any moves toward greater responsibility and autonomy must be matched with greater accountability, transparency and scrutiny. ICPs 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 the delivery of safe and effective care.
  - 3.20. If the Secretary of State for Health and Social Care is given legal duties to create new integrated NHS Trusts, there need to be safeguards to ensure that decisions about the health and social care workforce, from Government level to local provider are informed by a range of credible data and evidence. Any determination about 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. There must be a mechanism for transparency and scrutiny of these decisions, as well as ensuring that opportunities for data collection and reporting are enhanced, and not diminished, through structural changes to providers.
  - 3.21. There are a number of components which should be included as part of the mechanism for scrutinising decisions, for example:
    - Delays/bottle-necks between different parts of the service(s).
    - Clinical effectiveness – the type of scrutiny will depend on the services under contract – but should include external scrutiny from peers, professional bodies and regulators.
    - Effective incident reporting and learning mechanisms.
    - Patient experience – scrutiny by bodies such as Healthwatch.
  - 3.22. We also seek reassurance that increased deployment of the ICP contract will not lead to a diminishing of the nursing voice or leadership role within services, as they come together under one contract. Therefore, opportunities for nurse representation and staff-side discussions should be promoted, and executive nurse posts should be protected.
  - 3.23. We note that experiences of the first ICP contract (yet to be awarded) with Dudley CCG has come up against a number of challenges in the procurement process. Recent Board minutes highlight the risk of ongoing delays in the process to staff members<sup>7</sup>. The report stated that ‘staff who deliver the services would become more unsettled’ as the process took longer than expected. This indicates that there is a need for further development of the contract and implementation process before there are attempts made to roll-out further. This is necessary to provide stability for staff delivering services. We are continuing to consult with our members and staff across England to test this initial position.
  - 3.24. *Managing the NHS's resources better: This is the proposal NHSI be given powers to direct mergers where there are clear patient benefits, and set annual capital spending limits for Foundation trusts.*
  - 3.25. Under these proposals, NHS Improvement would have expanded powers to direct mergers or acquisitions involving NHS foundation trusts where there are ‘clear patient benefits’. Further clarity and detail 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.
  - 3.26. *Every part of the NHS working together: This is the proposed change which would allow CCGs and trusts to work together as joint committees (rather than establishing Integrated Care Systems as separate legal entities).*
  - 3.27. This proposal would mean that CCGs and NHS providers would be given the ability to create joint committees which could exercise functions and make joint decisions. As we have set out above, we recommend that these committees (Integrated Care Systems) should be given specific functions or remits related to assessing local population needs, workforce planning and contributing towards the delivery of a national workforce strategy.
  - 3.28. These committees provide an opportunity for supporting and coordinating local workforce activities. By bringing together both commissioning and provider functions, they are uniquely placed to determine local population need, understand the relevant workforce

- requirements, and communicate this to national bodies.
- 3.29. Currently, the relevant sections of planning guidance for Integrated Care Systems do not give any explicit steer to undertake this type of workforce planning. Moving forward, as these proposals remove the legal barriers preventing joint working, the requirements of these bodies in relation to workforce must be made explicit.
- 3.30. Alongside specific duties for these committees, there should also be a specific mechanism for ensuring that there are increased collaborative efforts to deliver relevant provider and commissioner legal duties in the relation to the workforce. For example, we are proposing that CCGs have responsibilities for delivering clear objectives as part of national workforce strategy. These joint committees would provide a good opportunity for working collaboratively to deliver on these objectives.
- 3.31. Likewise, there are activities which could be undertaken within these committees to be able to support providers to meet their legal duties related to staffing. In particular, this would include support for workforce planning, joint efforts on recruitment and retention strategies and feedback-loops related to changing patient needs.
- 3.32. Our members highlighted that this proposal would go some way to addressing current challenges within the system, such as the ‘gap’ between acute and community services for children and young people, and in particular the transition between children’s and adult services.
- 3.33. We welcome the proposal to allow registered nurses and doctors from local providers to sit on CCG governance. However, some of our members have highlighted that there are benefits which came from the independence of registered nurses and doctors from out of area. We ask that there are considerations made about ensuring learning from other areas can still be captured.
- 3.34. *Shared responsibility for the NHS: This proposal is the introduction of a new shared duty for CCGs and Providers to promote the ‘triple aim’ of better health for everyone, better care for all patients, and efficient use of NHS resources.*
- 3.35. We welcome the introduction of a shared legal duty. We consider this an ideal opportunity to include a specific legal duty related to the workforce, through expansion of the proposed duty. Workforce planning should be a core component of service design and planning. If not, services cannot be delivered safely or effectively without the right numbers and skills in the right places.
- 3.36. *Planning our services together: This is the proposal that groups of CCGs be given the ability to collaborate to arrange services for their combined populations.*
- 3.37. 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 design and deliver services with the workforce they need to ensure safe and effective care.
- 3.38. *Joined-up national leadership: This is the proposal that NHSE\I merge, and that the Secretary of State for Health and Social Care be given powers to transfer functions between ALBs, or to create new functions for them.*
- 3.39. We broadly support the intention of these 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. Existing mechanisms have proven not to be sufficient for the Secretary of State to direct the system with regard to workforce, as we have set out above. If the frameworks or structures are not able to deliver comprehensive workforce planning, they are not able to produce high quality service design planning.
- 3.40. We note that there could be potential for conflict of responsibilities within the lead

national NHS organisation, 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.

### 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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Policy and Public Affairs UK and International  
Royal College of Nursing  
April 2019

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Published by the Royal College of Nursing  
20 Cavendish Square  
London  
W1G 0RN

020 7409 3333

April 2019  
007 644



Royal College  
of Nursing