Royal College of Nursing

Staffing for Safe and Effective Care in England

Standing up for patient and public safety

ENGLAND POLICY REPORT

Royal College of Nursing

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Foreword

Throughout history, and across the world, the nursing profession has spoken out for patient and public protection and safety. The voices of nursing staff belong in all conversations and decisions, locally and nationally, about patient care. The significant nursing shortage in England – 12% vacancy rate in the NHS without counting social care, public health or primary care – means inadequate staffing levels across all settings. With an over-reliance on temporary staff filling gaps, we know that that the shortage is putting patients at risk and pushing nurses to leave the profession they love due to the pressures they face.

We also know that the long standing and significant issues for nursing supply and planning in England have not yet been resolved, nor long term solutions identified. This is in part due to the complexity and fragmentation of the devolved health and care system. The risk to patients' safety is unacceptable and we are standing up to say that they deserve better. We are reaching out to the public to join us through a public advertising campaign, which we launched on Patient Safety Day (17th September). While we deeply appreciate and value all the contributions of our colleagues from overseas, it is not sustainable to be reliant upon other countries above growing domestic supply. The pace and scale of growth needed to meet the needs of the population is significant. It is essential that everyone with a role to play is clear about their responsibilities, and what is in their gift to do for the short and long term.

The NHS has recognised that workforce roles and responsibilities need to be reviewed, and that government is best placed to lead this.

Our members know that protecting the rights of patients requires legal duties for all contributors to workforce supply and planning to be set out in legislation. There are opportunities for government to take this forward. The question now is not 'Should we?' but 'How should we?'.

Law is understood to be a key component in safety critical industries. For health and care, specifically, other countries in the UK have taken significant steps towards securing accountability for workforce supply and planning. Other parts of the world have done the same, and many are campaigning right now. Government should be clearly accountable for the sufficient provision of workforce to safely and effectively deliver taxpayer-funded health and care services. Government must create and maintain a labour market from which to recruit, retain, support and pay professionals delivering care to people living in England. Our patients deserve nothing less. Yes, this will this require investment. The safety of our patients depends on it, as does the health and productivity of the whole population.

There is a real opportunity for government to take sustainable action to resolve the supply crisis in England. Whatever the means of securing legislation, we are clear that legislation is essential. Doing this will leave a lasting legacy, closing the door on boom and bust approaches which serve no one. Our patients deserve no less than this, and neither do our nursing staff and other professionals across all health and care services. So let's get this moving.

Dame Donna Kinnair
Chief Executive & General Secretary, Royal College of Nursing

Executive summary

Despite government rhetoric that there are 'more nurses than ever before', we know that growth of the workforce is not keeping pace with demand for health and care services. In the last year alone for every extra NHS nurse employed there have been an extra 217 admissions[1]. This is simply unsustainable, and our members have been clear about the impact on their patients, and the risks of an unresolved shortage.

In their recent proposals for the update to the Health and Social Care Act, NHS England and Improvement recommend that government "review whether national responsibilities and duties in relation to workforce functions are sufficiently clear" [2]. We very much welcome this recognition from the health and care system that a review of duties is required. The aim of this review should be enabling all the players with a role in workforce supply and planning to understand their own responsibilities, and what they can expect from others.

Without this clarity, it has been a challenge for the Government and the system to come together to find solutions to the workforce crisis, and to understand their respective roles. There are still no long term solutions, nor funding, to ensure an overall supply of nurses and nursing staff across the breadth of publicly funded health and social care services. Solutions to date have been short term, and the direction of travel to incentivise new recruits into shortage areas will siphon off workforce into the services under the highest pressure. Poor retention, as well as drop off in supply to non-incentivised areas, would be inevitable.

Our members know that patients and the public deserve better, now and in the future. The public is also clear that supply needs resolving. When surveyed, 80% of respondents in England agreed that *"the Government should have a legal responsibility to ensure there are enough nursing staff to meet the country's needs"*[3].

The update to the legislation is clearly the ideal opportunity for the Government to take action on clarifying roles, responsibilities and accountability for workforce planning and supply in England. There is a need for planned, phased implementation, given the scale of the work needed.

Our members are more than aware that a legal framework for workforce duties is not the only solution. The People Plan being developed by NHS England and Improvement must set out a full workforce strategy, with fully costed, and funded, short and long term solutions for supply, recruitment, retention and remuneration. This must include plans for investment in nursing supply, calculated by the RCN to require at least £1bn per year for nursing education, to cover nursing undergraduate and postgraduate pre-registration tuition fees and maintenance grants, as well as post-registration training and development for the existing workforce.

This reports sets out – again – the impact of the nursing shortages on staffing levels across health and care services, and on the health and safety of patients. We present here our analysis of the current legislation and regulatory frameworks, and the benefits of specific workforce duties. We also provide recommendations for government, and system players, as well as commitments from the RCN.

Introduction

While the health and care workforce gap is growing, patient need for care continues to rise. It will take some years to start closing the workforce gap, yet patients need care and nursing staff need support now. In England this gap now stands at over 100,000 vacancies across all the professions in the NHS, with thousands more in social care and public health[4]. It's time to ask how did the crisis become so serious and what needs to happen now?

It is widely understood that when health and care services are understaffed, patient care, safety and outcomes are compromised, and so is the health and wellbeing of the professionals caring for them[5].

In 2017 nursing staff from across England described the impact which shortages have upon the care that they were able to deliver[6]. Further analysis of this large data from the response to the survey has shown that:

- when there were less than 50% of the registered nurses that had been planned for on their shift, nursing staff were almost **twice as likely to report that care was compromised** in comparison to those who were working with the planned number of registered nurses that were supposed to be in place
- respondents with less than half the registered nurses planned for on their shift were **four times more likely to report that care was 'poor' or 'very poor'**, in comparisons to respondents who were working with all planned for registered nurses on shift
- less than half of respondents with a full complement of registered nurses missed their break, compared to **more than 80% of respondents who were unable to take breaks** when they had less than half of the registered nurses due to be in place during the shift
- nursing staff with less than half of the registered nurses planned for on shift **worked an average of 23 minutes more** additional time than colleagues who were working on shift with the planned number of registered nursing staff. Overall, 93% of nursing staff working in NHS providers were not paid for additional time[7].

Nursing staff are more likely to report care as:

- compromised
- of poor quality
- or left undone when services are understaffed.

Shortages have an impact on the quality of care, and increase the likelihood of missed care and adverse events[8].

While there is no question that meaningful action will require expenditure, investment provides a wider return in terms of population health, socio-economic mobility and national productivity. The workforce is also vital to health and care service delivery, and public health provision. This is key to improving population health – an important determinant of national productivity, high employment rates and low levels of sickness absence[9]. In turn, this is critical to economic growth.

The World Bank[10] sets this position out clearly, stating that delivering care which is not of sufficient quality contributes to unmet health needs and may increase the likelihood of mortality and risk arising from poor health. It also identifies that a lack of investment in health and care, including in the health and care workforce, 'exerts a substantial economic impact' both in terms of correcting preventable complications of care and patient harm, which it estimates accounts for 15% of hospital expenditure in high-income countries[11], and lost productivity. National workforce strategies should incorporate these factors in determining the value on return of investment.

Inadequate investment in the workforce to meet the needs of the population directly impacts upon patient care, and upon population outcomes. Failure to invest is a false economy. The spending round in September 2019 did not provide the investment required in the health and care workforce, and so a further opportunity has been missed.

There is a specific need for sustained investment in the higher education route into nursing. This route has the best ability to deliver registered nurses at pace and scale. Currently the numbers coming through this route are insufficient, and over time this will lead to a greater increase in the workforce gap.

Despite a small (4%) increase in acceptances on A-level results day in 2019 compared to 2018, the overall number of acceptances is 8% lower than it was in 2016, the final year of the bursary in England[12]. The RCN is clear that there is a need for at least £1bn additional extra funding every year to incentivise a significant increase in the number of people studying nursing and to support them while they study and for a large increase in workforce development for nurses currently in the workforce, along with an expansion in clinical placements[13]. This will lead to an increase in the numbers of new registered nurses entering the workforce and begin to reduce the scale of the shortages.

The Government has set out an ambitious agenda for the health and care service, with a particular emphasis on care and support in the community. Within the NHS Long Term Plan it was acknowledged that transformation requires investment in order to deliver an existing service whilst also developing the community service offer. The same principles for investment in service transformation should apply to workforce supply and planning to deliver the transformed service. There is currently a lack of clarity on the accountabilities, roles and responsibilities for workforce supply and planning for all those with a role to play in contributing, in Government and throughout the health and care system. This should take the form of clear legal duties and powers which embed workforce planning into service design and finance planning. Securing this clarity requires legislation, to be able to future-proof decisions and accountability for workforce.

Our members are calling for:

1. A costed and funded workforce strategy with short- and long-term solutions for health and care workforce supply, recruitment and retention

Government and the system must publish a fully costed and funded national workforce strategy, which understands and responds to the challenges the health and care system is facing, including the experiences of the workforce. It needs to set out credible long term solutions to address challenges, and allocate the necessary funding to implement those solutions.

Significant investment in growing and developing the health and care workforce will help meet current needs within services as well as prepare for the future. For nursing, higher education is the largest and most effective supply pipeline. The 2016 funding reforms led by Government failed to generate growth as intended.

Incentives need to:

- support students while they study through tuition and maintenance support
- increase the number of clinical placements across routes into nursing
- properly fund a massive increase in workforce development for nurses and nursing staff to upskill the current workforce to meet current and future necessary skills for service transformation.

Analysis concludes that the Government must invest at least £1bn per year into nursing education in England[14]. This investment could be used to provide forgivable loans for tuition in return for working in public service; an option which would aid retention in the nursing workforce. This level of investment would also give further support for post-graduate routes into the nursing profession[15].

2. Clear legal duties and accountability for all those who contribute to workforce supply and planning

A legal framework must explicitly clarify roles, responsibilities and accountability for supply, recruitment, retention and remuneration of the health and care workforce. Legislation would introduce clear roles for multiple levels of decision-making throughout the health and care system, supported by phased implementation.

Recent progress has been made by the Government and health system towards understanding the causes of the workforce crisis, and some of the interventions needed. There has also been a shift in the leadership and collaborative working practice of national bodies, and designing an operating model for the workforce. Essentially the Secretary of State for Health and Social Care, and the health system have needed to work together to reverse-engineer

roles and responsibilities, where this is currently ill-defined. This is not therefore embedded in practice or future-proofed. Approaches in which there is accountable decision making related to workforce need to be strengthened and codified in law to ensure that they are hardwired in for future system leaders, as well as addressing gaps.

The Long Term Plan needs the right number of health and care staff in the right place at the right time. It makes sense to clarify accountability for workforce alongside accountabilities for other aspects of local and national service design and planning.

There is a clear opportunity for the Government to address these issues, substantially, in full, and to future-proof our health and care system once and for all. Leaders within the NHS have proposed an NHS Integrated Care Bill [16]. Accountability for workforce supply, recruitment, retention and remuneration – within Government, and throughout agencies nationally, and organisations locally – should be core to this update.

Law alone is not the answer, but as with all other aspects of Government and system roles in service planning, and quality, it is a fundamental part of it. Implementation can be phased, when fully understood and planned.

The scale of the workforce shortage in nursing

While there are major issues with nearly all aspects of workforce in health and care services, the system has stated that the most urgent challenge is the shortage of nurses[17]. In the NHS in England alone there are now 43,617 vacant posts for what is already funded and in place - the full 'establishment' of around 356,000 registered nurse roles employed by NHS providers[18]. This vacancy figure has increased by more than 10% from the previous quarter. In social care settings the picture is similar: 20% of registered nurse posts have been lost since 2012, and the vacancy rate is around 10%[19].

As an example, some parts of the nursing workforce have shrunk at an alarming rate since 2010 - numbers of district nurses providing working for NHS trusts in the community are down by 40%[20]. This is despite being pivotal to delivering the expansion in community NHS services set out in the NHS Long Term Plan.

The July 2019 NHS Patient Safety strategy acknowledges the risk which understaffing can have to ensuring patient safety[21]. It is clear that there cannot be safe and effective care without the right numbers of nursing staff with the right skills, in the right place at the right time. All the necessary steps for transparency and scrutiny are taken, to provide assurance to the public and to the system that care can be safe and effective. The key will be how this strategy is implemented.

Government responses to concerns about the nursing workforce often cite the fact that there are "more nurses now than there ever have been"[a]. While this is factually correct, it is disingenuous to use this figure alone, as there are also more patients than there ever have been, and these patients are living longer, with increasing frailty, more long-term health conditions and complex needs. Increases in the nursing workforce have not kept up with rising needs or demands for health and care services (figure 1)[22,23,24]. In real terms, this means that for every additional nurse added to the workforce in NHS acute settings in the last five years, there have been 157 additional admissions. In the last year this rose to 217 additional admissions for every extra nurse.

a Secretary of State for Health and Social Care, Matt Hancock – 7th May 2019. "The good news is that we have record numbers of nurses in the NHS. We have more staff in the NHS than at any time in its history." [Available at **http://bit.ly/2Vuhvyg**]

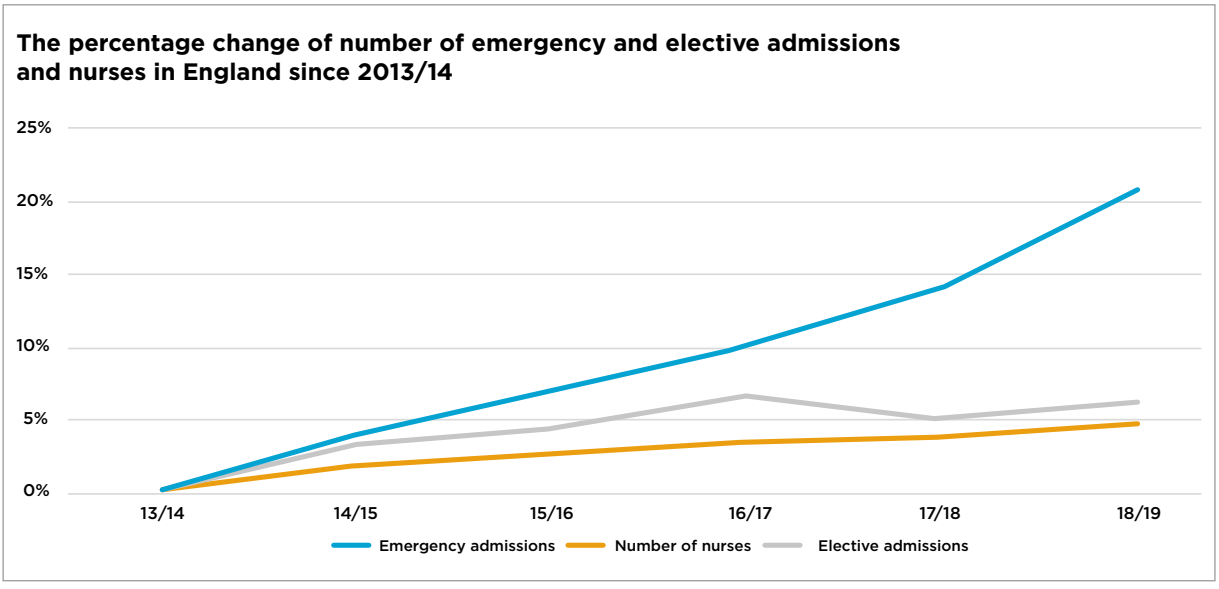


Figure 1: Growth of nursing workforce compared to increased emergency demand and elective admissions

It also presumes that the numbers of those coming in through training are sufficient to fulfill the need within existing services – which they are clearly not, with a vacancy rate of 11% in NHS trusts[25]. Simon Stevens, Chief Executive of NHS England stated that hospitals are unable to cope with the growing number of patients, and that expanding the number of acute beds will also require an expansion of nursing staff[26].

Outside of the NHS it is more difficult to accurately assess the size and shape of the workforce, because the coverage of data in independently-provided services and services commissioned by local authorities is extremely limited. This in itself is a problem for transparency and for the development of a credible national workforce strategy. However, cuts to local authority budgets and the public health grant have reduced the number of nurses working in care homes as well as radically reduced the number of health visitors, school nurses and sexual health nurses working in services[27].

Since 2017, the number of nurses in England joining the professional register (for the first time) has consistently been lower than the number of people leaving the register[28]. Although this is not the first time the number of leavers has been more than the number of joiners, the current context of uncertainty around the international workforce due to Brexit will reduce the ability of the system to address this imbalance.

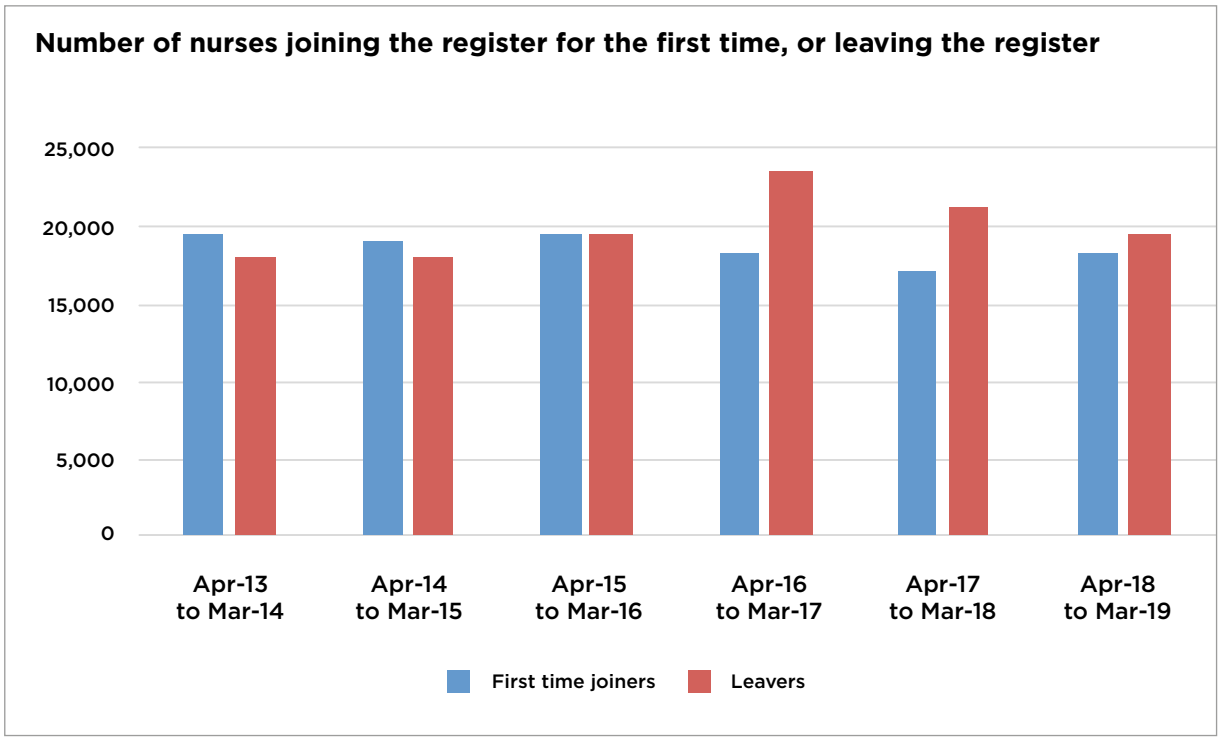


Figure 2: Numbers of nurses joining or leaving the NMC register in England

What is the impact on patient care?

There is a wide range of academic evidence that staffing levels are linked with the safety and effectiveness of their care and their outcomes. This is true in all settings, since insufficient staffing can result in missed care[29]. This issue is one which the public clearly recognise and care about. When surveyed in 2019, 71% of members of the public had the view that "there are too few nurses to provide safe care to patients"[30]. 28% of the public were concerned that they would not get the care that was required when needed, and 16% were concerned the care might not be of a safe standard[31].

Despite the fact that national agencies, regional bodies and local providers consistently raise the impact of shortages, there is no centralised, visible or transparent monitoring by Government or coordination across the health and care system to allow for vital scrutiny into the workforce crisis.

Other parts of the UK have identified the need to do exactly this. In Northern Ireland, the *Delivering Care* framework[32] sets out the methods by which Trusts present information about staffing alongside data related to patient care. Specifically, indicators including nurse staffing ranges, vacancy rates and absence rates are captured alongside measures of safe and effective care (such as number of falls or delayed medications) and measures of patient experience (including time spent with nursing staff) within a dashboard[33]. There is a recognition that monitoring this data can provide assurance about the effectiveness of workforce planning, and can highlight the need for a review of nurse staffing levels[34].

In Wales, implementation of the Nurse Staffing Levels (Wales) Act means providers are now required to collect and report on data related to staffing levels and patient care. This includes, specifically, the 'impact on care of not maintaining the nurse staffing levels'[35]. Indicators include pressure sores, falls, medication errors and complaints, within a specific incident reporting system[36].

In Scotland, the Health and Care (Staffing) (Scotland) Act puts a duty on every Health Board to make arrangements for real-time staffing assessments. This assessment includes the identification of risks caused by staffing levels which may impact on the health, wellbeing and safety of patients. There is also a risk escalation process in place[37].

Without similar transparency or data in England, the RCN has further investigated data previously captured from 30,000 nursing staff to further develop understanding of the link between patient care and staffing levels[38]. Systemic staffing shortages are already leading to instances of poor care. Essential care is left undone, mistakes are more likely to happen and patients have to wait longer for treatment[39]. More than half (53%) of respondents in England said that care was compromised on their last shift because of staffing levels[40]. Nurses, nursing staff and patients are failed when there is poor decision-making in the system.

73% of respondents in England reported that they were able to raise concerns about staffing levels, but 43% of respondents said that concerns were not dealt with[41]. It is critically important that providers of publicly funded health and care services take ownership of their data to inform their service planning decisions. We present here further analysis of this data, to understand the impact of staffing levels on patient care.

The respondents to this survey were from a range of nursing roles, including registered nurses. The questions we asked as part of this survey related specifically to the number of planned and actual registered nurses on a shift.

These findings show that care is more likely to be compromised or left undone when shifts are understaffed. Respondents were clear about their fears of being prevented from providing the care their patients need[42].

- Nursing staff reporting less than 50% of the registered nurses planned for were almost twice as likely to report that care had been compromised in comparison to those who had the planned number.
- Respondents with less than half of planned registered nurses were four times more likely to report that care was 'poor' or 'very poor', in comparison to respondents with all of their planned registered nurses.
- A quarter of nursing staff reporting all planned registered nurses on shift reported that care was left undone, compared to half of those respondents with less than 50% of their planned registered nurses on shift.

- Less than half of respondents with the full complement of registered nurses missed their break, compared to more than 80% of respondents who were missing half of the registered nurses due on that shift.

See the Appendix on page 25 for full findings.

Who is currently in charge of workforce supply and planning?

Many of the decisions about the health and care system have been devolved to national bodies, through the Health and Social Care Act (2012). In law the Secretary of State has a duty to provide a 'comprehensive' health and care system. This overarching duty, currently held by the Secretary of State, could be interpreted as broad enough to implicitly include workforce. However, without a specific duty for workforce, the Secretary of State does not clearly have the powers to direct the system to address workforce supply or planning, and nor can the Secretary of State be clearly held to account for the role they should play.

Without clear roles and responsibilities for workforce, policy solutions are short term, do not tackle systemic issues, and do not reflect the clear need for sustained investment in supply. The NHS Pay Review Body report states that *"accountability for workforce planning continues to be dispersed across a number of bodies despite the need for system-wide solutions"* [43]. Here we set out the findings of analysis of current workforce roles and responsibilities in relation to each part of the decision-making process.

The Secretary of State for Health and Social Care	
What duties do they have?	**How does this work in practice?**
The Minister has an overall duty in law to provide a 'comprehensive' health and care system to meet the needs of the population.[b] This includes the responsibility to secure improvement in the physical and mental health of the people of England. In undertaking these duties, the Minister must pay particular regard to the effectiveness, safety and quality of health and care services.	There is no specific reference in any legislation which specifies their responsibility to make sure there are enough nursing and other professionals to meet the needs of the population. A recent court case has agreed that the Secretary of State's duties are broad and lack specificity[44].

b The Government has a duty in the Health and Social Care Act (2012) to 'secure that there is an effective system for the planning and delivery of education and training to persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England'.

Many of the decisions about the health service in England are implemented by 'Arm's length bodies' such as NHS England (NHSE) and Health Education England (HEE). There are issues with lack of clarity and structural barriers between these bodies. In recent months, there have been practical shifts which have been undertaken to align the work of the national bodies, such as collaboration on developing the interim NHS People Plan, and the Government's mandate for 2019/20 to HEE which is aligned to that of NHSE[45]. However, mandates are only a mechanism to describe the activities which a body should prioritise in respect to their legal powers and duties, so if the powers and duties are not clearly present in law, they cannot be straight forwardly mandated.

National Arm's Length Bodies	
What duties do they have?	**How does this work in practice?**
HEE has several relevant duties in law[c], including the duty to ensure there are sufficient numbers of health care workers available to work for the health service. NHSE do not have any specific workforce duties within their remit, and this limits the ability of the Secretary of State to compel them to act through their annual mandate.	No national body is accountable for ensuring that the right number of health and care staff, as outlined within a national strategy, are entering the system to meet patients' needs.
	Although HEE has funding to give to services for student placements, in reality there are other factors which need to be in place; including enough staff capacity to support students' learning. In the current context of shortages this is increasingly difficult.
	HEE cannot operate alone, and is dependent on services creating capacity for student placements in order to grow the workforce, as well as the level of funding they are given.
	At national level, there has been a focus on service and finance planning in the absence of workforce planning.
	For the first time, the 2019-20 mandate from the Government to Health Education England is aligned to that of NHS England and NHS Improvement. This is a welcome shift to continue embedding collaborative working. However these mandates are limited to the scope of the respective duties and powers each body holds.
	There is no equivalent national body for Local Authority funded care. This means that there is even less clarity on roles and responsibilities on workforce planning and supply in social care and public health services.

c The Care Act 2014 - Part 3, section 98. Health Education England (HEE) must exercise its functions with a view to ensuring that a sufficient number of persons with the skills and training to work as health care workers for the purposes of the health service is available to do so throughout England.

The final stage of workforce decision-making is within organisations who receive public money to provide health and care services.

Providers of publicly funded health and care services	
What duties do they have?	**How does this work in practice?**
Registered health and care service providers, and they are required to deploy "suitably qualified, competent, skilled and experienced persons"[d]. For those providing NHS-commissioned services, this requirement is also in the contracts which they hold.	Providers do not have any control over the national supply of nurses; they have limited financial leverage to incentivise people to work for them, and there are limits on the amount they can spend on agency staff.
	There are very few mechanisms available available to them to plan staffing with the the right numbers of nurses and other professionals with the right skills.
	The duties for providers of nurses and other professionals with the right skills do not have anything to link into within the health and care system. If providers fail to meet their duties there is a mechanism for penalising them, but there is not a mechanism for the system to be required to resolve the factors which contributed to it, including national supply issues.
	This could easily lead to instances of providers closing down becoming more common due to a lack of staff, but the system does not do anything about it. Providers may have to reduce or close a service due to unsafe staffing levels.

d The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing: 18.—(1) *Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.*

The role of legislation

Parts of the UK have taken steps to introduce workforce legislation:

Scotland

Following Scotland's First Minister Nicola Sturgeon MSP's announcement to introduce safe staffing legislation at the RCN Congress in 2016, the RCN in Scotland has been influencing how this legislation will ensure staffing levels to provide safe, high quality health and care services for Scotland[f]. The Health and Care (Staffing) (Scotland) Act 2019 received royal assent in June 2019. This legislation covers both the NHS and care services.[46]

Wales

RCN members in Wales helped secure the first law in Europe for safe and effective nurse staffing in 2016[e]. In practice, health boards and trusts have a legal duty with regard to ensuring appropriate levels of nurse staffing to enable nurses to care sensitively for patients in all settings. This law currently applies to adult acute medical and surgical wards, and the Welsh Government has committed to extending this to other settings .

Northern Ireland

Northern Ireland is currently without an Executive, and this makes progress on legislation challenging. However, the policy solution to this is the *Delivering Care* framework[47] which sets out guidance in relation to nurse staffing. This approach focuses on professional judgement and staffing ranges. At the moment there are few opportunities to secure accountability due to the lack of government, and the RCN will continue to engage the public on this issue.

e The Nurse Staffing Levels (Wales) Act 2016 [Full text available at **http://www.legislation.gov.uk/anaw/2016/5/contents/enacted**]

f The Health and Care (Staffing) (Scotland) Act 2019 [Full text available at **https://www.legislation.gov.uk/asp/2019/6/contents/enacted**]

What are the current system levers for staffing for safe and effective care – and are they working?

There are a number of system players and initiatives which make a contribution to supporting patient safety. This includes existing legislation and regulation. We set out here what is in place and why this is incomplete without specific workforce legislation.

Health and Safety Legislation and initiatives

The deployment of appropriate staffing levels is not explicitly referenced in the Health and Safety at Work Act (1974). It is implicit that many of the duties for employers can only be fulfilled if there are sufficient numbers of staff in place.

For example, employers are required to ensure the health, safety and welfare at work of all employees[48]. In fact, the RCN's staffing survey found that 65% of respondents in England were working additional time, and 45% felt exhausted and negative[49].

Similarly, employers have a requirement to provide an uninterrupted break during the working day[50], however, in practice we know that staffing shortages can mean that health and care staff are unable to take breaks or to eat during their shifts. 59% of respondents from England reported that they were not able to take sufficient breaks[51].

The RCN also hears from members who are put in difficult positions when moving or handling patients if there are not enough staff on shift to deploy the evidence-based approach to handling a patient. This could lead to patients being handled in a compromised way, leading to a risk of injury being caused to the patient or staff member. In the period between 2010 and 2015, manual handling compensation claims cost the NHS over £7 million, with inadequate staff available as a common theme in such claims[52].

The 2014 Mid Staffordshire NHS Foundation Trust case included the Trust pleading guilty to a breach of the Health and Safety at Work Act. The situation at Mid Staffordshire included a 'failure in management' to remedy the deficiencies in staff, amongst other issues[53]. The CQC is now responsible for identifying health and safety breaches relating to patients, a role previously undertaken by the HSE.

The prevalence of workplace stress within compensation claims is another indicator of the impact which poor staffing levels are having upon the health and care system; not just in terms of harm caused to patients, but also harm caused to staff, compromising health and safety legislation and requirements for employers. There are also financial implications, with claims related to stress and bullying over a five-year period totalling more than £27m in the NHS[54].

NHS Resolution is the body responsible for compensation claims related to clinical errors, negligence and injuries to members of staff or the public, on behalf of the NHS in England. The organisation aims to identify ways in which similar situations can be avoided. Their *Being Fair* report encourages a learning environment after incidents have occurred. This report includes information related to claims made by NHS staff relating to stress and bullying.

The harm to staff within these claims include[55]:

- stress at work caused by workload and lack of resources
- staff member felt they were obliged to work excessive hours leading to suffering a stress-related illness
- stress arising from failure to pay regard to complaint by staff member regarding staffing levels.

It is likely that clearer accountability for workforce issues would act as an enabler to allow the HSE to identify breaches of health and safety legislation. Currently, it could be that poor practice is being hidden due to staffing shortages and high turnover. Clear decision making processes for workforce planning would also aid the HSE to investigate the causes or contributing factors when an incident has occurred. The CQC would also be enabled to identify health and safety incidents relating

to patients, as currently all of the supporting elements are in place but the health and care workforce shortage continues to be unresolved.

Overall spending on litigation in the NHS is increasing rapidly. Between 2006 and 2018 payments to clinical negligence claims have quadrupled (from £400m to £2.2bn)[56]. The total cost of all the claims under NHS Resolution in 2018/19 has grown to £83.4bn, an increase of £6.4bn on the previous year[57]. It is more than likely that increasing gaps across the health and care workforce are contributing to increases in errors and missed opportunities, which have devastating implications for patients.

There is a large amount of resource going into improving patient safety and reducing both the likelihood and impact of clinical errors and injuries. NHS Improvement offers incentives for Trusts delivery on key maternity safety actions, and the 'Getting It Right First Time' programme seeks to improve care by reducing variation[58]. These programmes and initiatives are much more likely to be successful if they are being implemented into health and care settings which are fully and adequately staffed. Staffing for safe and effective care is critical to both avoiding the occurrence of clinical errors and to creating an environment in which patient safety and learning is prioritised. Here, clear accountability for workforce supply and planning throughout the system is the solution which would unlock the ability for the system to transform and improve.

Service regulation

The CQC is the regulatory body for health and care services. Regulation states that providers must deploy enough suitably qualified, competent, skilled and experienced staff[59]. The CQC has the legal power to take action against any provider who is not complying with this regulation. This can include giving warnings, making recommendations that a service be closed, or in extreme circumstances can apply to a magistrate for a service to be closed immediately[60].

In practice, however, there are some challenges with inspections in relation to this regulation. There is currently no consistent framework by which CQC inspectors can assess staffing levels[61]. Instead, they are reliant on information such as use of agency staff, shift patterns for particular time periods and staff turnover, and the pattern and frequency of patient incidents. The CQC cannot prosecute for a breach of this regulation, but they are able to take regulatory action[62]. Often, challenges to this regulation are pursued alongside breaches of other regulations, for example if there have been patient safety incidents during a shift when there are a higher proportion of agency staff[63].

The CQC's annual State of Care report stated that workforce problems have 'a direct impact on people's care'[64]. We recommend that the CQC uses the reporting mechanisms which it holds with the Department of Health and Social Care to share their expertise on these issues.

The Health Service Safety Investigations Body (HSSIB) investigates a number of cases each year where there is an opportunity to generate learning across the health and care system[65]. The creation of this body will go some way to shifting the system towards a 'safety critical' culture. In order to facilitate this shift, we recommend that all incidents which are investigated by HSSIB include reporting of and a review of staffing levels and skills mix. This will aid the understanding the system has on the impact of staffing levels upon patient safety, outcomes and experience. The scope of investigations should routinely include reporting on the concerns raised by health and care staff regarding staffing levels.

Building these elements into the approach taken by HSSIB on a proactive basis will help the system to learn from cases in which care has been compromised due to staffing levels. Coupled alongside clear accountability for supply, recruitment, retention and remuneration, this learning will enable HSSIB to communicate the learning to the system, and gain traction for it to be embedded.

Professional regulation

The Nursing and Midwifery Council (NMC) holds a professional regulatory responsibility, and like the CQC will be aware of many situations in which staffing levels are a relevant factor in cases where patients have been harmed or care has been left undone. It was welcome to see the NMC take some steps towards addressing this in their recent commitment to "understand the importance of considering the context of a case" in regard to Fitness to Practise cases[66].

As the NMC has recognised, it is important for it to work closely with employers to resolve these systemic issues. We believe this is particularly important in relation to staffing levels, to avoid situations of disproportionate individual blame. Beyond this, the NMC has a huge wealth of information about systemic staffing issues linked to individual Fitness to Practice cases. This information is important to help decision-makers understand the impact of staffing shortages, and to understand their role in enabling nurses to practice in a safe environment. We encourage the NMC to develop a mechanism for regularly identifying and sharing this data, as a key part of the organisation's strategy currently in development.

What is missing?

Alongside a lack of clarity on accountability for workforce, it is clear that the system is missing the necessary levers to provide assurance and scrutiny on decisions related to workforce recruitment, retention, remuneration and supply. There is currently a particular emphasis on levers, both legislative and non-legislative, at provider level, without reciprocal levers for other layers of decision making, such as commissioners or national bodies.

One major theme is a lack of robust workforce data throughout the system. There are huge gaps in workforce data from providers in the independent sector, in social care and public health. In practice this means that transparency or scrutiny is not a lever available to enable staffing for safe and effective care to be secured.

Is is clear that what is missing are specific legal duties for workforce for all those with a contribution to make to supply and planning, as part of health and care service design. As these must be introduced into legislation, it is now simply a matter of identifying how and when this can be done. We set out below what needs to be done to take this forward.

What needs to happen now?

Our members have set out five principles for legislation enabling staffing for safe and effective care. There are a range of actions attached to each of these:

Accountability - A governance framework that details responsibility and accountability for ensuring an adequate supply of registered nurses and nursing support staff is available throughout the health and social care system to meet the needs of the population.

The Secretary of State for Health and Social Care can:

- lead the debate on roles, responsibilities and accountability for workforce supply and planning within the health and care system, including taking a clear view on what their own role must be
- ensure the inclusion of accountability for workforce supply and planning in the NHS Integrated Care Bill by the end of 2019.

Government can:

- support amendments to the NHS Integrated Care Bill and include accountability in law for the supply, recruitment, retention and remuneration of the health and care workforce and support clarity in the roles and responsibilities for layers of decision making, covering all publicly funded health and care services.

Parliament can:

- support the inclusion of legal duties for the Secretary of State and health and care arm's length bodies specifically for supply, recruitment, retention and remuneration within law when tthe NHS Integrated Care Bill goes through its legislative stages
- champion further appropriate legislative changes to ensure that clarity on roles, responsibilities and accountability is secured for the health and care workforce outside the NHS, including social care and public health.

The Royal College of Nursing will:

- RCN members will lead a campaign to raise awareness amongst the public about the need for allocating funding towards growing and developing the health and care workforce, to support national conversations to be held.
- The RCN will lobby for legislation and supporting statutory instruments to be in place for each country of the UK that clearly demonstrates specific accountability within each health and care system to ensure that nurse staffing is appropriate to provide safe and effective care.

Numbers - Ensuring that the right number of registered nurses and nursing support staff with the right knowledge, skills and experience are in the right place at the right time.

The Department of Health and Social Care can:

- take steps to collect, monitor and report on workforce data from all publicly funded health and care services, with delivery from April 2020. This level of transparency is essential to being able to assess the areas with the highest risk of care being compromised due to a lack of staff. It will also enable greater scrutiny regarding the impact of national policy decisions.

The Secretary of State for Health and Social Care can:

- set an annual increase rate of workforce growth, in line with increases in population demand, and implement any necessary strategies and investments to achieve this level of growth. This should be in place before the 2020 financial year begins.

The Royal College of Nursing will:

- produce guidance on nurse staffing levels and skill mix with other nursing roles to support decision making within the health and care system

Strategy - A workforce strategy addressing national, regional and local levels, detailing the overall aim, strategic objectives and required actions.

The Prime Minister needs to:

- lead a national conversation with the public about the future of health and care services in England, and the need for additional investment
- commit to long term funding settlements

for public health and social care, including provision for the public health and social care workforces, for workforce growth now and in the future.

HM Treasury can:

- ensure that the NHS People Plan is a fully costed, fully funded workforce strategy which reconciles workforce supply, recruitment, retention and remuneration with population need for primary care, public health social care services, and with government ambitions.

The Secretary of State for Health and Social Care can:

- publish a green paper setting out the options for securing sustainable funding for social care, including growth and development of the social care workforce.

Plans - Workforce plans developed at national, regional and local level to support strategic objectives as detailed in the workforce strategy.

Arm's Length Bodies must:

- support all health and care providers to collect and report on workforce data, and make this data publicly available to support robust workforce planning throughout the system.

Regulatory bodies such as the NMC and CQC can:

- use the reporting mechanisms it holds with the Department of Health and Social Care to robustly communicate trends in workforce supply, recruitment, retention and remuneration, and to describe the impact of staffing shortages on the delivery of safe and effective care.

Providers of publicly funded health and care services must ensure that:

- they have the right numbers of registered nurses with the right knowledge, skills and experience, in the right place, at the right time to provide safe and effective nursing care to patients.
- Decision making in relation to nurse staffing must be informed by legislation, NMC requirements, national regional and local policy, research evidence, professional guidance, patient numbers, complexity and acuity, the care environment and professional judgement.

The Royal College of Nursing will:

- continue to demonstrate the impact which staffing shortages are having upon safe and effective care

Education - Robust commissioning arrangements for pre- and post-registration education and development.

HM Treasury can:

- Identify funding to invest in growth and development of the entire health and care workforce, including at least £1bn per year in the supply and development of registered nurses. This must take into consideration the needs of public health, social care and primary care alongside health services, as there are not separate routes into those parts of the profession. In order to make an impact from the 2020/21 academic year onwards, this funding must be secured immediately. Costed modelling can be found in the RCN's report *Fund our future nurses (2018).*
- Offer incentives for higher education nursing students to study nursing and be retained within the workforce upon graduation. These incentives need to support students while they study through tuition and maintenance support. This could include the option of offering forgivable loans for nursing students, or tuition and maintenance grants, for both undergraduate and postgraduate nursing students.
- Invest in increasing the number of clinical placement across routes into nursing, and properly fund a massive increase in workforce development for nurses to upskill the current workforce to meet current and future necessary skills for service transformation.

The Royal College of Nursing will:

- Work with the Nursing and Midwifery Council, and with Higher Education Institutions, to ensure the development of patient safety curricula, and enable nurses and nursing staff to advocate for the safety of their patients without fear of negative repercussion.

Frequently asked questions

"Where should the money to invest in nursing supply come from?"

Whilst the NHS did receive extra money recently, it did not include allocations for workforce, nor has additional funding for social care and public health been provided. There is a real need for the Government to commit to sufficient funding allocations for workforce, as well as to these parts of the systems to provide stability and prevent pressures in one area adding pressure on the NHS. When allocations are designed for public health and social care, they must include funding for growing and developing the workforce.

However, when considering the NHS alone, the NHS People Plan has clearly highlighted the need for additional funding for workforce[67]. Workforce planning has not been integrated into decisions about service design or financial planning. When requests for additional money were made, they did not include the amount needed to grow and sustain the workforce.

Supply is needed for the whole of the health and care system. There is a need for HM Treasury to consider growth and development of the workforce.

When polled, members of the public ranked 'recruiting more nurses' as the highest priority for additional funding, with 37% of respondents selecting it as their first option[68].

"Isn't it possible to change the way the system works without legislation?"

The system has recently adopted a more collaborative working style to explore workforce issues. Although there is more to be done to strengthen this approach, it should be embedded within legislation so that future post-holders and system configurations share the responsibility for making assessments and implementing important decisions related to the workforce for the health and care system as a whole.

Particularly in a time of political change and uncertainty, it is important to make sure that there is a consistent and codified approach to ensuring the health and care system has enough staff to run it, and provide safe and effective care.

"Why should we get the Judiciary involved in the health service?"

The legal system in England provides an important check and balance for the implementation of law. It is important that the vital elements which contribute to a comprehensive health and care system are given an appropriate level of scrutiny, both within the system and from external sources. This can ensure that patients are receiving the best quality of care, and public funds are being spent in the most effective way. Without this type of scrutiny, no one can have sufficient assurance about patient safety, service quality or financial decisions.

"Why is the RCN campaigning for law? Shouldn't they be focussed on just getting more nurses to the frontline?"

There isn't a choice to be made about campaigning for law or campaigning for more nurses; we need both to be addressed to resolve the current workforce crisis and prevent future problems from occurring. We need investment, long term solutions and legislation to future proof the approach.

With tens of thousands of vacant nursing posts, urgent action is needed. This also requires an additional investment of at least £1bn per year in nursing higher education[69].

However, this investment alone would not future-proof workforce supply. Fixing legislation would create a system in which decisions about the future workforce needs for the health and care system are made proactively, and appropriate levels of investment and incentives are put towards generating supply to meet those needs. Each part of the system would be clear about their roles and contributions towards achieving the right level of supply.

"Aren't there more nurses than ever before?"

Looking at the numbers of nurses in isolation from indicators of population need does not show you the full picture. Yes, there are more registered nurses than there ever have been before, but there are also more patients. And, those patients will live longer with more complex long term health conditions. We can see that the nursing workforce has been growing at a slower rate than demand for health and care services. Demand is outstripping supply[70].

We also know that there are parts of the nursing workforce which have seen serious declines in size over the last few years. In particular this applies to district nurses, mental health nurses and learning disability nurses working in NHS trusts in England[71].

Planning the size and shape of the nursing workforce should be based on a robust assessment of population need, and as the demand for health and care support grows, so should the nursing workforce.

"Doesn't Health Education England have responsibility for workforce supply?"

HEE has clear duties and powers related to the system of generating workforce supply and providing training and education[i]. For nursing, this is a market-led model, (a student loan since 2016) and as such, HEE has very limited control in order to increase supply. HEE are often regarded as having responsibility for workforce, but does not have the tools and funding to invest in education provision to increase supply to meet the needs of the population.

There are not enough health and care staff coming through the various routes into the professions, there have been cuts to CPD and there is no workforce strategy containing costed short and long term solutions.

i The Care Act 2014 - Part 3, section 98. Health Education England (HEE) must exercise its functions with a view to ensuring that a sufficient number of persons with the skills and training to work as health care workers for the purposes of the health service is available to do so throughout England.

"Won't the NHS People Plan solve the workforce crisis?"

The Interim NHS People Plan recognises and states that national action must be prioritised to tackle the nursing shortages; the shortfall of nursing staff is described as the most urgent challenge facing the health care workforce in England[72]. Critically, this plan just applies to the NHS workforce and does not offer any assessment or solutions for those working in public health, primary care or social care.

What we have seen so far is the description of a challenge, rather than an action plan for solving it. This needs to be resolved in the final version of the plan.

However, alongside a final workforce strategy and additional investment, legislation is needed to avoid future workforce crises. Without clear accountability, there is no mechanism for the system to understand how to deliver the outcomes set out in any plan, or ensure that this situation does not happen again.

"Does accountability for workforce supply need to mean investment?"

Given that there are so many gaps in the health and care workforce, there is a requirement for additional funding. However, it's important that this funding is not simply seen as a 'cost'. An investment in the health and care workforce provides clear and significant benefits. For example, evidence shows that when appropriate staffing levels are maintained, patients tend to have shorter stays in hospitals.

Wider than this, there is also a relationship between an investment in the health and care workforce, and the improvement this can bring to the health outcomes of the population. In turn, this means the population are healthier, and therefore are more productive, and productivity leads to economic growth.

So ultimately, yes, this would require significant investment, but that would generate benefits for people's health, for workforce stability, would produce a good return on investment and provide assurance that the health and care system is safe and effective. In any case, the Government should be investing in initiatives like this, so that individuals are not put in situations where their health is compromised and their quality of life put at risk due to avoidable staffing shortages in the health and care system.

"Does this give more power to the Secretary of State for Health and Social Care?"

The Secretary of State for Health and Care has legal duties to deliver and improve the health and care system. However, the 2012 reforms did have the effect of making the lines of accountability less clear. At Government level there is a legal duty to ensure the comprehensive provision of the health and care service, but limited power or operational responsibility to make change[ii]. In reality there is no legal expectation that the Secretary of State is explicit about workforce requirements but they still need to get assurance from the system that it is delivering on their duties. Rather than one part of the system holding all the powers necessary to deliver this assurance, it is split across a number of bodies. For some of these bodies, the roles and responsibilities are not clear.

Clarifying these roles, responsibilities and accountability for workforce planning and supply will go some way towards addressing this imbalance and separation. Additionally, the Secretary of State would have a clearer, more formal accountability role with clear duties and powers for relevant national and local bodies.

ii The Government has a duty in the Health and Social Care Act (2012) to 'secure that there is an effective system for the planning and delivery of education and training to persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England'.

"What about local authority controlled social care and public health?"

We are calling for a legal framework of accountability for workforce planning and supply which covers all publicly funded health and care services. This includes social care and public health. This will also include the independent sector when they are providing publicly funded health and care services.

The supply of health and care staff into the system is not divided into NHS, social care and public health; there is just one supply line feeding all parts of the health and care system. People are likely to move between settings and sectors throughout their careers, and as services become increasingly integrated. Therefore, this framework needs to cover all parts of the system. This would ensure that determinations about how many health and care staff are required are based upon a robust assessment of need for all parts of the system, not just the NHS. Likewise, reporting on workforce shortages and gaps in particular areas should feed into adjustments made to the supply line.

"Law alone doesn't change everything – what else needs to happen?"

Clear legal duties in law will help prevent future workforce crises from arising. There are also things needed now to resolve the workforce crisis we are currently in.

A fully costed and funded national workforce strategy for health and care is needed. Some elements of this will be contained within the final NHS People Plan, but further development is needed for social care and public health.

Alongside this, there is a need for urgent investment in the supply and development of the health and care workforce. This should include incentives for students where required, financial support for those on clinical placements and funding for continuing professional development (CPD).

"Is there any evidence that having law will actually change things?"

Around the world, there are a number of countries who have already taken steps and implemented legislation related to workforce and staffing for publicly funded services. Much of the evaluation and academic research which has been undertaken to assess the implementation of these laws has been positive. Findings show that waiting times are reduced, lengths of stays are decreased, and avoidable mortality rates in health and care services improve.

Appendix

Care is compromised when shifts have fewer registered nurses than planned

Nursing staff who had less than 50% of the registered nurses they had planned for were almost twice as likely to report that care had been compromised in comparison to those who had the planned number of registered nurses.

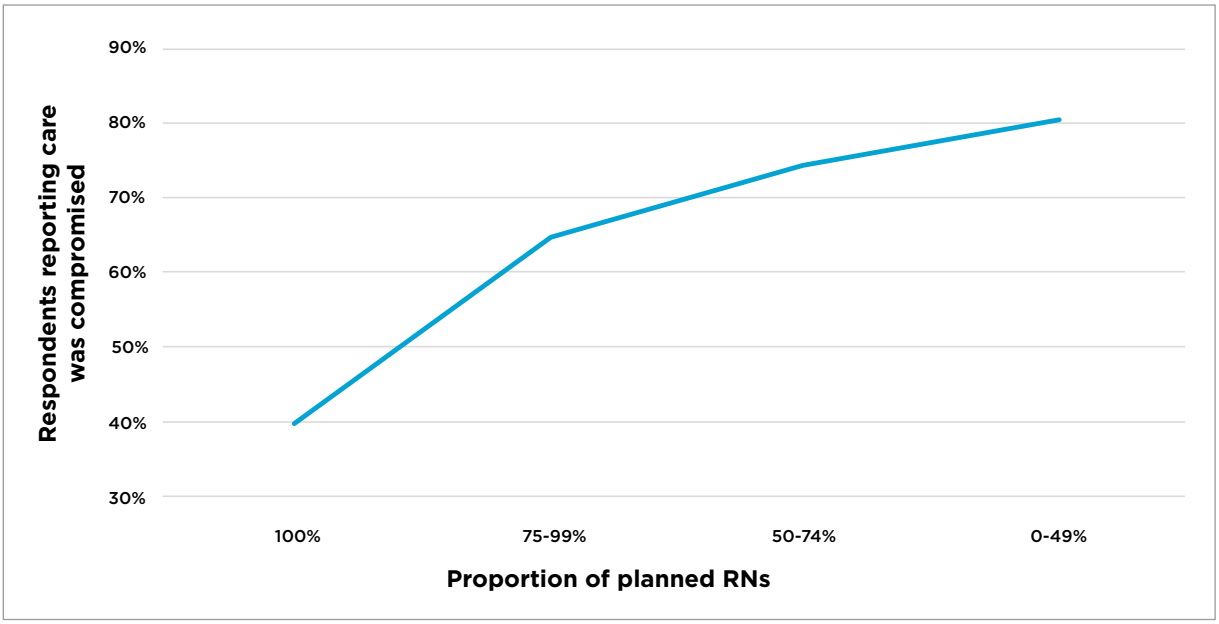


Figure 3: Reporting of care being compromised when shifts have less registered nurses than planned in England

There was some variation across different types of settings. Respondents from community settings were less likely to report that care had been compromised when staffing levels were short, compared to care homes and hospitals.

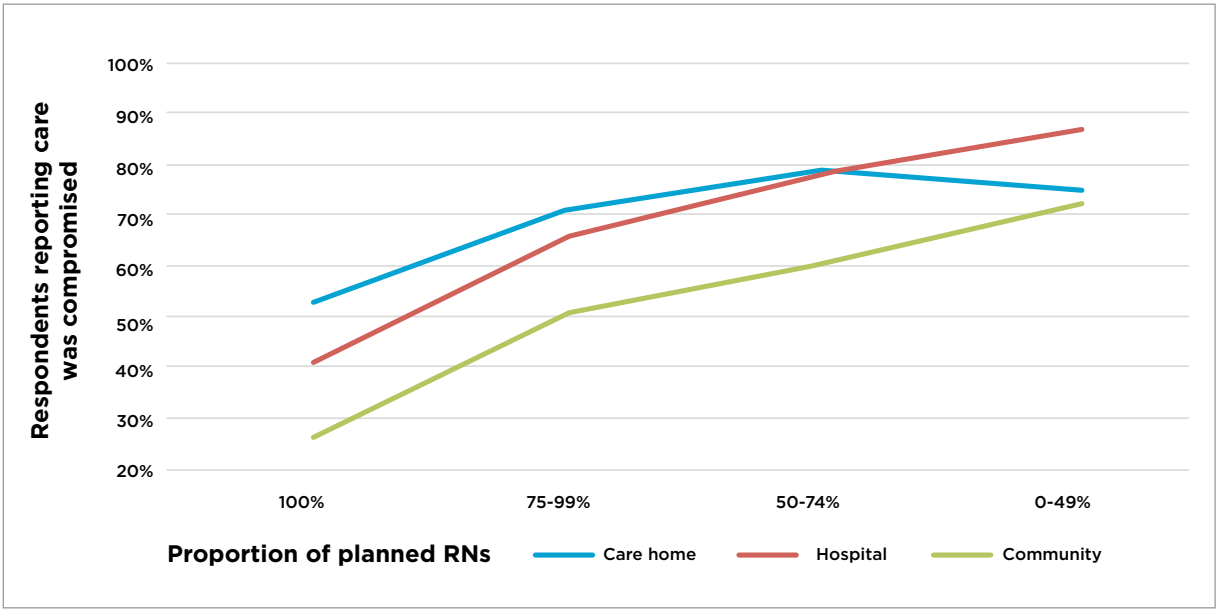


Figure 4: Reporting of care being compromised when shifts have fewer registered nurses than planned (by setting) in England

Poorer quality care is delivered when shifts have fewer registered nurses than planned

A similar trend was also found in the relationship between those who had a higher proportion of the planned registered nurses on shift and those reporting that the quality of care on that shift as being 'good' or 'very good'. Respondents with fewer than half of planned registered nurses were four times more likely to report that care was 'poor' or 'very poor', in comparison to respondents with all of their planned registered nurses.

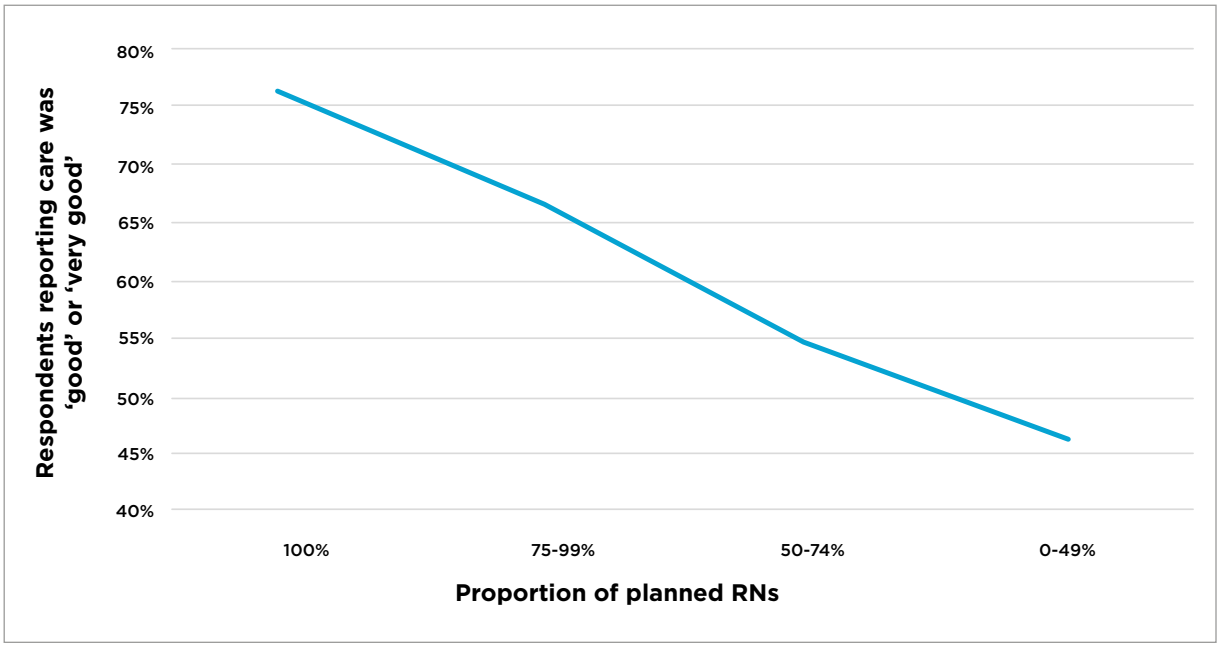


Figure 5: Reporting of care quality being 'good' or 'very good' when shifts have fewer registered nurses than planned in England

Care is left undone when shifts have fewer registered nurses than planned

Those respondents with the full complement of registered nurses were also much less likely to report that necessary care had been left undone. Just over a quarter of those with all the planned registered nurses on shift reported that care was left undone, compared to half of those respondents with less than 50% of their planned registered nurses on shift.

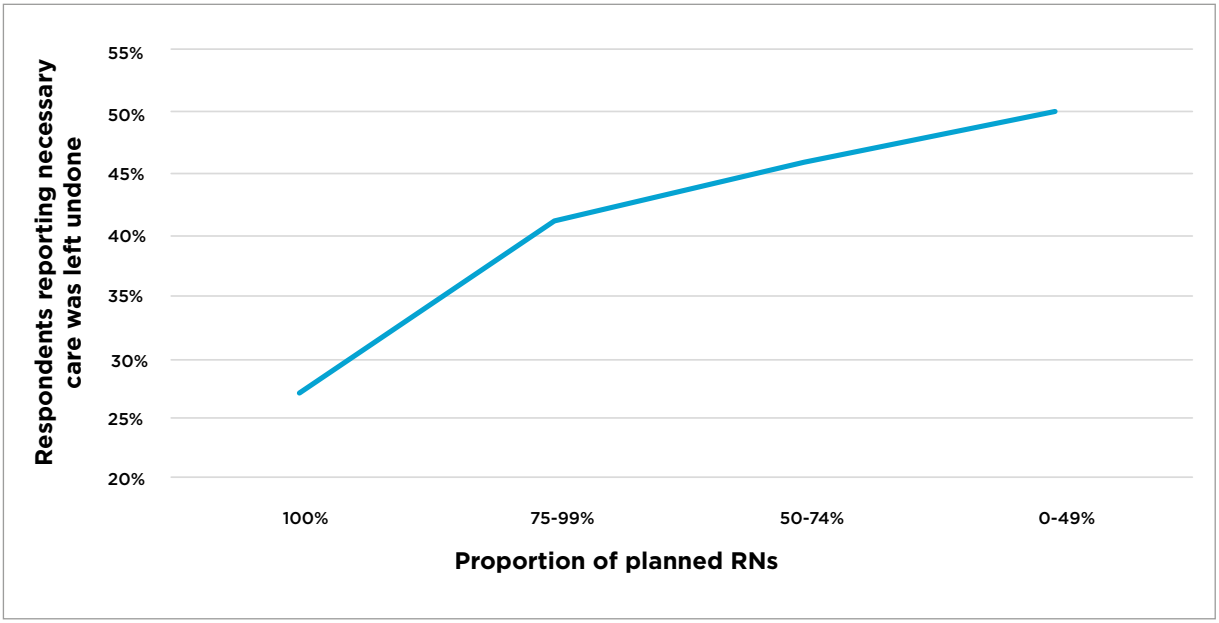


Figure 6: Reporting of care being left undone when shifts have fewer registered nurses than planned in England

A similar trend was found when comparing respondents from different types of settings. Here, respondents from hospital settings with less than half their planned numbers of registered nurses were more likely to report that care was left undone. There is increasing evidence globally and in the UK through published academic research which confirms this correlation in hospital settings. Research from the University of Southampton found that higher nurse staffing levels are associated with lower mortality in hospital settings[73]. There are several possible reasons for this, including that higher nurse staffing levels reduce the likelihood that care, including vital observations, is left undone.

Early findings from the implementation of staffing legislation in Queensland, Australia show a reduction in avoidable patient deaths and decreases in lengths of stay in hospital when staffing levels are improved[74].

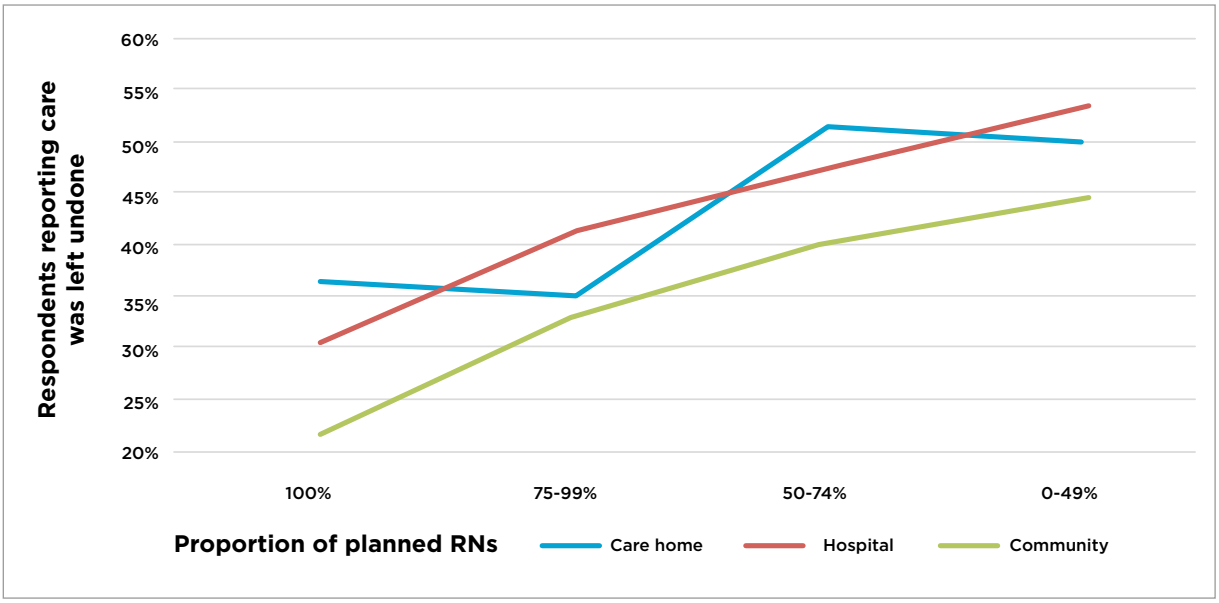


Figure 7: Reporting of care being compromised when shifts have less registered nurses than planned (by setting) in England

Nursing staff are missing breaks when shifts have fewer registered nurses than planned

There was also a relationship between the proportion of planned registered nurses who were on shift and the likelihood of respondents to be able to take a break. Less than half of respondents with the full complement of registered nurses missed their break, compared to more than 80% of respondents who were missing half of the registered nurses due on that shift.

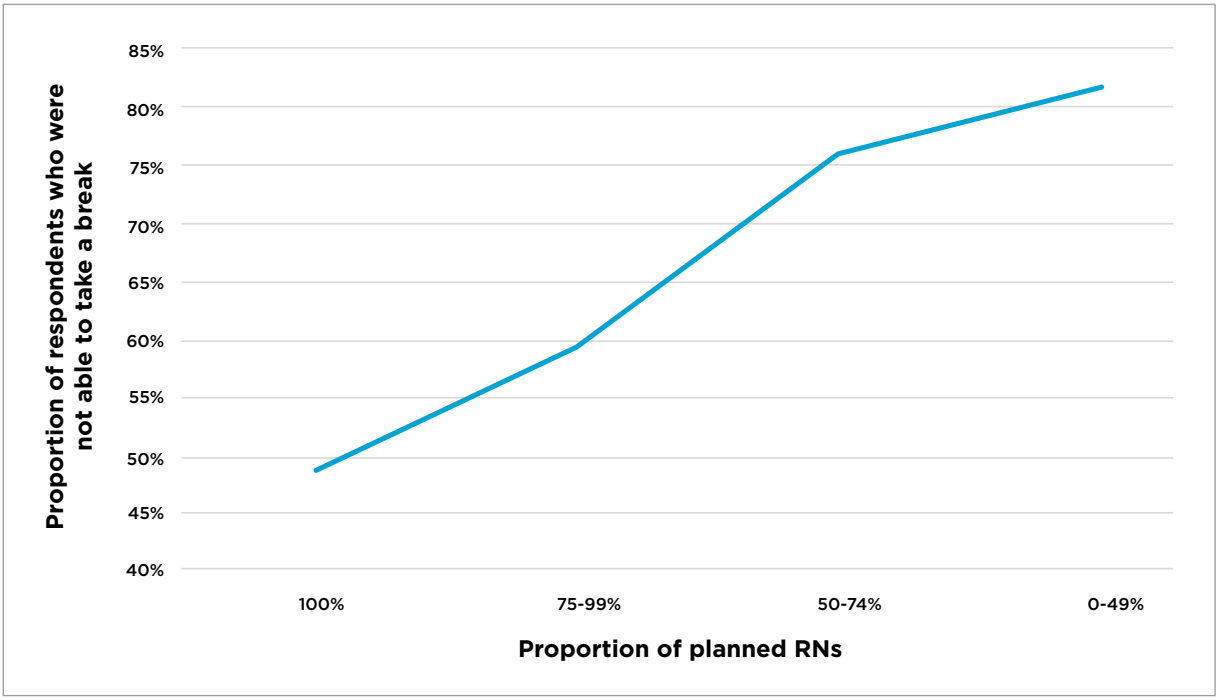


Figure 8: Reporting of nursing staff missing breaks when shifts have fewer registered nurses than planned in England

Regularly missing rest breaks is not sustainable for nursing staff, and can lead to nurses becoming unwell or burnt out with an increased desire to leave their job[75]. There is also evidence indicating that staff members who are tired and dehydrated will be affected in terms of their cognition, and may be more likely to make mistakes[76]. Fatigue is recognised by the Health and Safety Executive as a key factor resulting in reduced ability to process information and underestimation of risk, amongst other issues, and can contribute to incidents[77].

Nursing staff are working additional time when shifts have less registered nurses than planned

Respondents who had less registered nurses than planned on shift were also more likely to work overtime. Of the respondents with the full number of planned registered nurses, 57% reported that they had worked overtime. This is compared with 75% of respondents who had less than three quarters of the registered nurses they had planned for, and 77% of respondents with less than half the complement of registered nurses. 93% of nursing staff working in NHS providers were not paid for additional time[78].

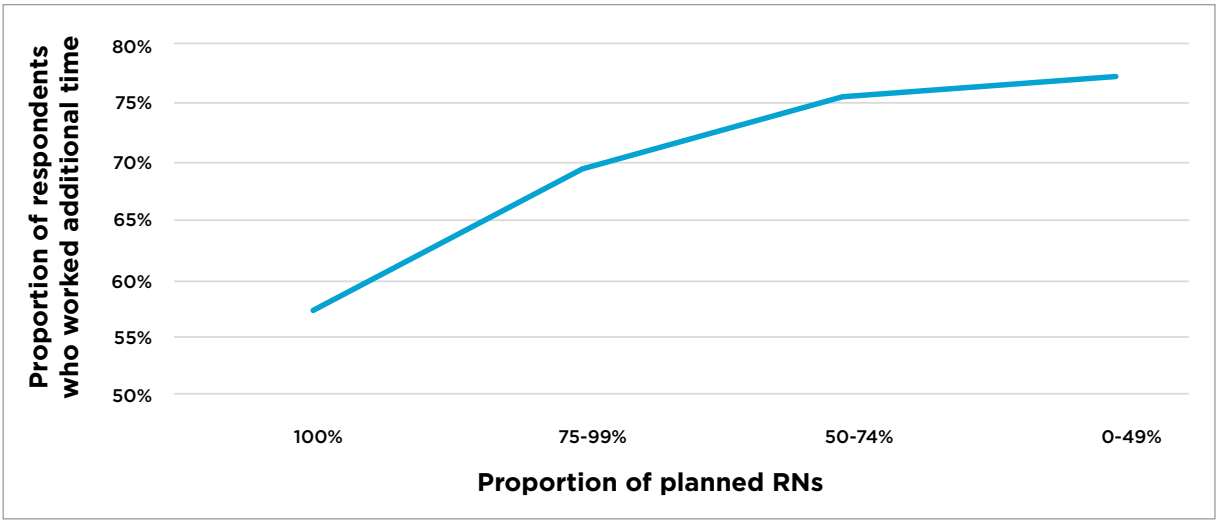
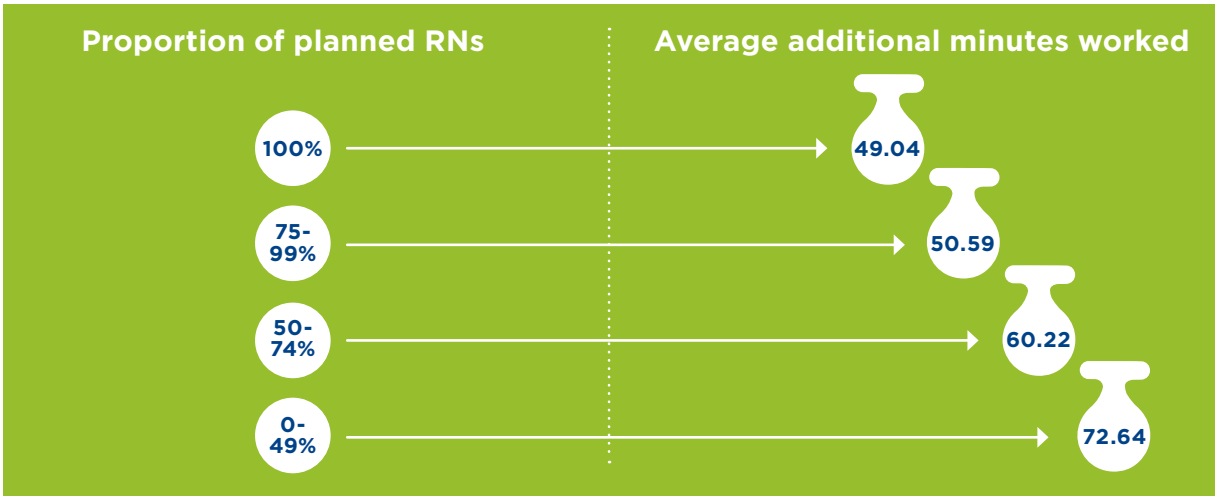


Figure 9: Reporting of nursing staff working additional time when shifts have less registered nurses than planned in England

Not only is working additional time more likely for those with staff shortages, but the average additional time they work is higher than colleagues who have the full complement of registered nurses.



On average, the respondents with less than half of their planned registered nurses worked 23 minutes more additional time on that shift than their colleagues who had all the registered nurses they planned for. Regularly working overtime can contribute to nursing staff experiencing fatigue, which could lead to an increased chance of errors[79]. It also means that the breaks which staff are getting between shifts are reduced, so staff don't have as much time to recover. This will also impact upon nursing staff with caring responsibilities whose work-life balance is regularly disrupted by overtime. There was also a slightly higher chance of respondents who had all of their planned registered nurses reporting that they were paid for their additional time (12% were paid) in comparison to those with less than half their planned registered nurses (7% were paid).

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