RCN submission to the Health and Social Care Select Committee inquiry on implementing the NHS long-term plan

Summary and recommendations

- Successive governments have failed to effectively align workforce planning, service design and funding cycles to plan and deliver health and social care services. All three components must be aligned if the NHS Long Term Plan (LTP) is to be successfully implemented. Currently in England, workforce supply and planning are not consistently integrated into service and finance planning at all levels of decision-making in the health and care system. While the NHS has received a five year funding settlement, the long term budgets for education and training, social care, public health and NHS capital budgets are still unknown. These recognised interdependencies, if not addressed, will undermine implementation of the NHS LTP.

- The implementation of the LTP is contingent on having the right amount of clinical staff, at the right time and in the right place across all health, social care and public health settings. However, a succession of ineffective workforce planning policies and a lack of oversight and responsibility for national workforce planning has led to a crisis in the nursing workforce in England. A continuation of this lack of workforce planning will act as a significant barrier to the implementation of the LTP. This accountability gap should be addressed in the future by placing a new legal duty on the Secretary of State to ensure they are ultimately accountable for workforce supply, recruitment, retention and remuneration.

- Despite the rhetoric from Government that that there are more nurses now than ever before, our analysis has shown that the rate of growth of the nursing workforce over the last 10 years (up ~3%) is much lower than that of key demand indicators for health and care services, such as the increase in emergency patient admissions (up ~20%).[i] Within the last year there has been a shift in the approach taken by Government and health leaders and a more collaborative approach has developed, specifically through the NHS People Plan. However, these efforts must go farther than acknowledging the challenge and must set out clear and specific interventions in the final NHS People Plan to be actioned. This must include investing at least £1 billion per year into nursing higher education to grow the nursing workforce at the scale and pace needed in order to meet the ambitions set out in the LTP.[ii]

- The Government's decision to delay the long term funding allocations for education and training, NHS capital budgets, social care and public health budgets until next year is a significant risk. The one year Government Spending Review[iii] does not provide the certainty the system needs to strategically invest in increasing the future nursing workforce supply and develop the current workforce with the skills and knowledge needed to drive service improvement. This lack of a longer term investment will have significant knock on effects for the final NHS People plan and delay planned service expansion across a range of areas earmarked for improvement in the LTP. Already, the Government has missed the opportunity to significantly bolster the intake of new nursing students in the 2019 academic recruitment round by missing another opportunity to significantly grow the future supply of registered nurses to the level needed to deliver the LTP over the next five years.

- The Government must see the broader benefit and return on investment of funding the health and care workforce. The World Bank identify 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 lost productivity and correcting preventable complications of care and patient harm.[iv] As there is a an average three year lead in time to educate new nurses to close the workforce gap, an on-going failure to invest in the workforce at pace and scale will have long-term implications for population health.

Additional information

Implications for education and training

1.1 The LTP aims to reduce the nursing vacancy rate in the NHS to 5%. However, the modelling and assumptions underpinning this figure, and the extent to which this accurately reflects predicted patient demand are unknown. Even though the nursing supply generates supply for social care and public health, there is no assurance this is understood in either modelling assumptions or ongoing development of solutions. Furthermore, the current 11% vacancy rate for nursing in the NHS is based on current funded full time nursing posts (the establishment).[v] That is not the same as the number of nurses NHS England needs, it's the estimated number of vacant posts it has funding for.

1.2 The LTP sets out a number of specific goals that cannot be met without significant investment in education and training for workforce supply now. For example, community services are now seeing transformation investment alongside spending on acute services. This is the first time in recent years that the system has recognised the need to 'double' invest in services for the purpose of transformation. Growing and transforming the workforce to deliver this new service configuration also requires investment, and this approach should be incorporated into service design and delivery.

1.3 In addition, the focus on children and young people's mental health services and learning disabilities services is a positive step. However, there can be no increased delivery in, or increased efficacy of, mental health and learning disability service delivery without a sufficient supply of new staff. Since May 2010, there has been significant reductions in mental health and learning disability nurses working in the NHS, -10.6% and -39.8%[vi] respectively. Furthermore, these branches of nursing continue to decline in the wake of the removal of the NHS bursary for nursing students in 2016. This is in turn is leading to a vicious cycle in which a lack of financial viability forces universities to close many of their courses, further limiting the ability of people to studying these courses in many parts of England.

1.4 The healthcare funding reforms of 2016 have failed to generate the rise in students which was the stated aim of the reforms. From 2016-19, there has been a -8% reduction in the number of students accepted onto nursing degree courses since the bursary model was removed.[vii] Although Government narrative suggests that there are more nursing students in England and that this has happened as a consequence of reforms in 2016, the full context is that reforms have failed in their attempt to grow the number of nursing students.

Investing in nursing higher education must be prioritised

1.5 Although the collaboration across the system to devise the interim People Plan has been promising, the Plan contained no new significant funded solutions to address long term workforce supply and planning issues. The only way to meet this supply need at the necessary scale and pace is through the established pre-registration higher education routes. The established undergraduate route must be the primary route as it is the only way to grow the nursing workforce at the necessary scale and pace required to grow overall supply to meet service demand across health, social care and public health.

1.6 The focus must be to substantially increase overall supply through the introduction of financial incentives across the main graduate nursing courses. Failure to invest in overall supply will lead to the shifting of a finite pool of nursing staff from one crisis area to another, as well as placing newly qualified staff within extremely pressured working environments and potentially increasing staff turnover rates. Specific clinical shortage areas, such as learning disabilities and mental health, could have additional targeted incentives to encourage uptake. The RCN is calling for the Government to invest at least £1 billion per year into nursing higher education to incentivise more people into nursing and grow the nursing workforce.

Prioritising new routes into nursing alone cannot meet the supply of registered nurses needed

1.7 The LTP and interim NHS People Plan place a strong emphasis on additional routes into nursing. However, this strategic emphasis on these new routes cannot generate the number of nursing students needed to begin to address the NHS, social care and public health workforce vacancy crisis, much less population need.

1.8 There are a number of flaws in the way both nursing degree apprenticeships and nursing associates are set up. The Apprenticeship Levy does not cover back fill costs for staff and it creates a significant extra cost for employers; with the risk to the employer of any money not accessed for an apprenticeship within that time is diverted to HM Treasury after 24 months. Furthermore, the Secretary of State for Health and Social Care does not have the power to address these issues as the levers for the apprenticeship model sit outside the health and social care system and there is no apparent commitment from Government to change anything to make nursing degrees apprenticeships more viable. Finally, Health Education England have consistently said that 40% of nursing associates would go on to become registered nurses. However, the assumptions this workforce projection is based on has not been published.

Continuing professional development for nurses must be significantly increased beyond 2015/16 funding levels

1.9 CPD is essential to both retain and incentivise current staff and to develop the current workforce to deliver the transformative goals outlined in the LTP and People Plan. The interim People Plan says that the Health Education England budget for CPD will be returned to levels before it was cut in 2015/16. The RCN has consistently said that restoration of the HEE workforce development budget in five years to the level of 2015/16 is vastly insufficient. Not only is this figure out of date, much less in real terms, it contains no account of changing population and workforce needs, nor is it modelled against actual goals of workforce development and service transformation.

2 The RCN have costed some illustrative models to demonstrate the scale of cost required for a given trust and where possible, the system as a whole, for three key aspects of CPD:

2.1.1 Practice Assessors Training model: this model is structured around the premise that every registered nurse, midwife and nursing associate would be capable of and required to support all pre- and post-registration nurse education delivered and assessed in the workplace.

2.1.2 Preceptorship model: newly registered nurses need an additional period of support in their new role. This support is called preceptorship and is designed to help develop confidence and enhance competence, critical thinking and decision-making skills.

2.1.3 Work-based learning modules for specific training needs: this is a specialised CPD model that focuses on particular training requirements in an organisation.

2.2 This is not by any means an exhaustive final bill for CPD, but demonstrates the scale of investment required if the LTP's goals are to be met on areas including clinical placement expansion, retention of new staff and service transformation. The full explanation and costing of the models is in appendix 1.

Specific implications for social care

3.1 The LTP makes it clear that it had been developed in terms of demand, activity and funding on the basis that social care funding is resolved.[viii] Without the funding settlement for social care being resolved, underfunding will continue to add pressure to health services, and will limit the ability for the LTP to be delivered. The failure by Government to publish the Green Paper for adult social care demonstrates another inconsistent approach to services planning.

3.2 Successive Governments in England have not made funding decisions for adult social care based on a robust, transparent assessment of population need, or indeed to help ensure that the registered nurse and nursing staff workforce is in place. This means that local authorities are faced with impossible choices, and members of the public requiring social care do not have their needs met. The lack of funding, and ability to

generate additional income for Local Authorities means that the money they have available to provide social care is not enough for all those who need it. When thresholds for accessing support rise, those who would previously have qualified for support are left without the help they need. In turn, this then places more pressure on other services, particularly general practice and older people's inpatient hospital settings. Health services are put under pressure too; when social care settings are not available, individuals may experience delayed discharges where they take up a hospital bed. This means that funding for health services is spent supporting individuals whose needs would be better met in social care services, if the provision was there.

3.3 The LTP makes it clear that it had been developed in terms of demand, activity and funding on the basis that social care funding is resolved.[ix] Without the funding settlement for social care being resolved, underfunding will continue to add pressure to health services, and will limit the ability for the LTP to be delivered. The failure by Government to publish the Green Paper for adult social care demonstrates another inconsistent approach to services planning.

3.4 Much of the ambition of the LTP is related to increased provision of community services. These services are particularly vulnerable to increased demand when social care provision is not sufficient to meet the needs of the population. This reduces the capacity of community services to be able to deliver the level of activity outlined in the LTP. At the same time the community nursing workforce is experiencing massive cuts - there has been a -42.6% reduction in district nursing numbers since May 2010.[x]

The nursing workforce crisis in social care

3.5 There are not enough registered nurses and support workers to deliver safe and effective care in adult social care settings such as nursing homes and residential care homes. The Government is not addressing this as the NHS People Plan is focused purely on the nursing workforce needed in the NHS. This is a significant missed opportunity to concurrently grow the future supply of registered nurses needed for social care, the NHS and public health services.

3.6 The number of registered nurses working in social care settings in England decreased by nearly 20% between 2012 and 2017, despite an ageing population with increasing care needs[xi]. Data is limited in its coverage because Local Authorities (LAs) are not required to collect this information from all providers. Moreover, data shows that while the number of registered nurses is declining, the number of healthcare workers is increasing. Skills for Care reports that while the registered nurse workforce decreased by 18.45% between 2012 and 2017, the number of care workers increased by 13.70% in the same time period.[xii] The RCN is concerned that inappropriate substitution of skills leads to poorer outcomes for people using these services.

Specific implications for public health

The Government's Green Paper on prevention lacks workforce and funding commitments

4.1 We welcome the Government's recently launched Green Paper on prevention.[xiii] However, we have serious concerns about the lack of any sustainable funding package for public health and prevention and the broader funding crisis facing LAs. Adequate and sustained investment, along with workforce modelling projections or solutions for how Government will grow the nursing workforce needed to deliver the prevention agenda, will be essential for the Government to achieve its ambitions.

Funding pressures

4.2 The Government's £20.5bn financial uplift for the NHS does not include an allocation for public health, and in fact the public health grant from central Government to LAs to commission public health services has been cut by £700 million in real terms between 2014/15 and 2019/20.[xiv] This reduction in community health services by LA is occurring at the same time when the NHS recognises the value of investing in primary

and community services to achieve better health outcomes and help reduce demand on acute services. The fragmentation between NHS and LA priorities must be resolved by Government and local health and care systems together in order for care pathways to be truly safe and effective, integrated, and to deliver optimal population health.

4.3 Financial pressure has hindered the ability and capacity of LAs to deliver their public health functions and has resulted in cuts to key services including smoking cessation, health visiting, school nursing, sexual health and drug and alcohol misuse services whilst demand is increasing.[xv] This is within a broader context of cuts to central government funding for local authorities of nearly 50% since 2010-11.[xvi] This has led to a fall in spending on services in England by 21% between 2009-10 and 2017-18.[xvii] Cuts to the public health budget and wider LA budgets are contributing to unacceptable variation in the quality and quantity of services available, and threaten to exacerbate health inequalities.

Future funding uncertainties

4.4 The Government's plans to replace the public health grant from 2020 with retained business rates pose a risk to the sustainability and effectiveness of LA funded public health services. Without assurance or certainty about how much LAs will spend on public health, and on what, there is a risk of further reductions in public health spending as cash-strapped LAs struggle to balance budgets. These LAs often have the poorest population health outcomes yet they lack the resource and funding to invest in public health services.

4.5 The funding mechanism for public health delivered through LAs must enable transparency and accountability, and be sustainable and equitable. Therefore, the formula for funding public health must be based on an assessment of local health needs rather than the ability of a local authority to raise money. Any future funding allocations or mechanism for generating funding for public health must take into account the specific needs of different areas, and inequalities within different locations, particularly in rural areas given the geographical and workforce challenges many areas face.

Workforce pressures in public health nursing

4.6 In key areas of public health, notably health visiting and school nursing, RCN members report that services are being decommissioned and posts cut, whilst increasing demand for services and workload pressures are forcing many to leave the profession.[xviii] We have previously raised concerns about declining provision and take up of specialist community and public health nursing training courses.[xix] There are significant gaps in the data on the public health nursing workforce as many are employed outside of the NHS where data on the workforce is not routinely or consistently collected or available. This has prevented a full understanding of this part of the health and care workforce. However, we do know that the number of school nurses employed by the NHS fell 29.3% from May 2010 to April 2019. While the number of NHS health visitor posts fell from 10,309 in October 2015 to 7,121 in April 2019.[xx]

4.7 The impact of funding pressures and fragmented commissioning arrangements affecting public health were highlighted earlier this year when providers of public health services reported that they had not received adequate financial support to cover the NHS pay uplift which had been promised to their staff by the Government. The resulting row between service leaders and Government about who should pay for the uplift is symbolic of the fragmented funding arrangements and the lower priority accorded to public health services.[xxi]

About the Royal College of Nursing

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world. For more information, please contact John Considine, Public Affairs Adviser John.Considine@rcn.org.uk

Appendix 1: Illustrative models of CPD funding for clinical placement expansion, new graduate support and service transformation

Summary

- The cost estimates presented here provide an *indication* of the level of long-term investment needed to tackle issues around supply and retention of nursing staff in England.

- We understand that most of these models are developed and implemented at a local level and involve direct negotiations between those requiring training models (mainly NHS Trusts) and the providers which include defining the costs based on the local demand and market conditions. As such, one of the limitations of the modelling is not being able to account for the effect of the local conditions on the provision of CPD.

- Similarly, we could not provide a timeline for the completion of the training requirements for each of the models. We believe this will be guided by each Trust's budget availability and identification of specific training needs.

- Finally, we are unsure of any Brexit implications on these estimates and, therefore the models cannot anticipate any changes that might affect the costings presented here.

Practice Assessors Training Model

- This model is structured around the premise that every registered nurse, midwife and nursing associate would be capable of and required to support all pre- and post-registration nurse education delivered and assessed in the workplace. The early curriculum adopters are expected to have nursing students leaving the higher education with the skills needed to become ‘practice supervisors’ within the next three years.

- Approved Higher Educations Institution (HEIs) in partnership with NHS Trusts are currently providing training and supporting the development of ‘supervisory/ assessor’ skills among students and registered nursing staff across the UK. These standards for student supervision and assessment (SSSA) modules are replacing the previous mentorship models.

- However, differing HEIs and practice will be approaching this differently looking at ways of achieving the role through non-credited and potentially credited routes. The Nurse and Midwifery Council (NMC) indicates that nominated practice assessors ‘must either have some sort of preparation before taking up their roles’ or provide evidence of prior learning and/or experience required to meet the standards set by the NMC.

- Our evidence suggests that there is a gap in the educational requirements for the support of those staff engaging in the supervisory role.

- The NMC advocate that nurses who previously occupied the role of ‘mentors’ would become ‘practice assessors’. However, there is no data on the historical number of mentor nurses; therefore, it is difficult to estimate the number of nurses that would want to train as ‘practice assessors’. We know, however, that not every ‘practice supervisor’ would want to become a ‘practice assessor’

- It is important to highlight that in the current model the assessor could be any health care professional. However, our focus here is the nursing staff and, therefore, the cost estimates only refer to the nursing workforce.

- Based on this, we present cost estimates for different levels of training coverage:

- Based on NHS workforce statistics, we calculated there are 1,371 nurses and health visitors on average currently employed as full-time equivalents (FTEs) in each of the 217 NHS Trusts in England (ambulance trusts are not included). [xxii]
- We presented several scenarios assuming different levels of training coverage based on the above workforce data (i.e. 25%, 50%, 75% and 100% of nursing staff trained as practice assessors in each of the 217 NHS Trusts)[xxiii]
- Following the same methodology, we present costs estimates for nurses in primary care settings. According to the NHS, there are 16,384 (FTE) nurses working in primary care[xxiv]
- We have not included 'practice assessors' trained in the private sector.
- The RCN estimates a cost of £28,350 (plus VAT) for a cohort of 20 students (£1,417.50 per student)[xxv]

Estimated cost of training registered nurses as practice assessors in Hospital and Community Health Service settings

Costs	25% of RNs trained	50% of RNs trained	75% of RNs trained	100% of RNs trained
	343 nurses	686 nurses	1028 nurses	1371 nurses
Total cost for one Trust (Including VAT)	£583,443	£1,166,886	£1,748,628	£2,332,071
Total cost for all NHS Trusts (217)	£126,607,131	£253,214,262	£379,452,276	£506,059,407

Estimated cost of training registered nurses as practice assessors in Primary Care settings

Costs	25% of RNs in Primary care trained	50% of RNs in Primary care trained	75% of RNs in Primary care trained	100% of RNs in Primary care trained
	4096	8192	12288	16,384
Total cost for one Trust (Including VAT)	£6,967,296	£13,934,592	£20,901,888	£27,869,184

Preceptorship model

- The NMC advocates for a regular four-month period of preceptorship for all new registrants.[xxvi] We have based our assumptions on this to estimate the cost of the model in NHS England for the current year (2019):
- In 2018/19, 20,123 nurses and midwives joined the NMC register for the first time.
- By June 2019, 1,000 nursing associates had qualified and joined the NMC register[xxvii] (out of a cohort of 2000 Trainee nursing associates that began training in 2017). The government expected 'a further 5,000 beginning training in 2018, and a further 7,500 beginning in 2019[xxviii]
- A subsequent completion rate of 50% was applied to these estimates. This completion rate is based upon the best and most recently available data from the NMC on NA completion rates.[xxix]

- It will likely be the case that some of the first 2017 cohort who have not yet qualified will return to their training and eventually join the register in much the same way that happens for registered nurses. However, there is not yet any data available to demonstrate what this figure will be and thus we must use the only data available to us.
- Using the government's 'Return to Practice' initiative estimates that 1000 nurses will return to work as nurses in the UK, we assumed that 80% (800) of these nurses would join the workforce in England.
- We did not include HCSWs in these estimates as they do not need to register and this model applies only to newly registered practitioners entering the workforce in England.
- Costing based on preceptorship academy for 15 participants is £4,300 for a four-month period. We also present cost estimates for 6, 12, 18, 24 and 36 month-period preceptorship programmes.

Preceptorship model: Cost estimates for NHS England – 2019 (all costs include VAT)

	Potential new NHS staff in 2019	4 month-period preceptorship	6 month-period preceptorship	12 month-period preceptorship	18 month-period preceptorship	24 month-period preceptorship	36 month-period preceptorship
New nurses (NMC register)[xxx]	18,350	£6,312,400	£9,468,600	£18,937,200	£28,405,800	£37,874,400	£56,811,600
New nurse associates[xxxi]	1,000	£344,000	£516,000	£1,032,000	£1,548,000	£2,064,000	£3,096,000
Return to practice[xxxii]	800	£275,200	£412,800	£825,600	£1,238,400	£1,486,080	£2,476,800
Total of providing preceptorship for new NHS staff in 2019	20,150	£6,931,600	£10,397,400	£20,794,800	£31,192,200	£41,424,480	£62,384,400

Preceptorship model: Cost estimates for NHS England projected to 2020 (all costs include VAT)

	Potential new NHs staff in 2020	4 month-period preceptorship	6 month-period preceptorship	12 month-period preceptorship	18 month-period preceptorship	24 month-period preceptorship	36 month-period preceptorship
New nurses (NMC register)	17,147	£5,898,568	£8,847,852	£17,695,704	£26,543,556	£35,391,408	£53,087,112

New nurse associates	2,500 [xxxiii]	£860,000	£1,290,000	£2,580,000	£3,870,000	£5,160,000	£7,740,000
Return to practice	800	£275,200	£412,800	£825,600	£1,238,400	£1,486,080	£2,476,800
Total of providing preceptorship for new NHS staff in 2019	20,447	£7,033,768	£10,550,652	£21,101,304	£31,651,956	£42,037,488	£63,303,912

Preceptorship model: Cost estimates for NHS England projected to 2021 (all costs include VAT)

	Potential new NHs staff in 2021 [xxxiv]	**4 month-period preceptorship**	**6 month-period preceptorship**	**12 month-period preceptorship**	**18 month-period preceptorship**	**24 month-period preceptorship**	**36 month-period preceptorship**
New nurses (NMC register)	16,773	£5,769,912	£8,654,868	£17,309,736	£25,964,604	£34,619,472	£51,929,208
New nurse associates	3,750 [xxxv]	£1,290,000	£1,935,000	£3,870,000	£5,805,000	£7,740,000	£11,610,000
Return to practice	800	£275,200	£412,800	£825,600	£1,238,400	£1,486,080	£2,476,800
Total of providing preceptorship for new NHS staff in 2019	21,323	£7,335,112	£11,002,668	£22,005,336	£33,008,004	£43,845,552	£66,016,008

Work-based learning modules – for specific training needs

- This is a specialised CPD model that focuses on particular training requirements in an organisation. Work based learning supports the delivery of practice- based education within the clinical /HSC environment. Our assumptions for this model's cost estimates are as follows:
  - Our calculations are based on the assumption that each of the 217 NHS trusts in England (excluding ambulance trusts) has specific training needs.
  - We assumed that each of the 217 NHS Trusts in England (excluding ambulance trusts) had identified a specific training need that requires 'work-based learning modules' in 1, 5 and 10 different hospital area(s).
  - RCN estimates a cost of £23,950 (plus VAT) for a cohort of 20 learners (£1,197.50 per learner)

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[xxxiii] We calculated this number by assuming that a completion rate of 50% for this cohort of newly qualified nursing associates. From the first cohort of 2000 students that started training in 2017, by June 2019 only 1000 had joined the NMC register.

[xxxiv] Using the excel forecast formula, we projected the expected number of nurses to join the NMC register assuming they will also join the workforce in England

[xxxv] We calculated this number of newly qualified nursing associated by assuming a completion rate of 50%.