Health and Care Bill – Written evidence submitted by the Royal College of Nursing to the House of Commons Public Bill Committee

1. Introduction

1.1. With a membership of around 465,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

1.2. As the largest regulated healthcare profession, the complexity and autonomy of the Registered Nurse role, and the safety-critical standards of education and practice that the profession is held to, are fundamental to the effective design and delivery of health and care services, as well as addressing wider socio-economic determinants of health. Our nursing support worker community is also critical across health and social care settings, and can work independently, alongside nurses and as part of wider multidisciplinary teams, with a crucial role in delivering high quality care and excellent outcomes for patients.

1.3. This submission sets out our key concerns and proposed amendments to address gaps within the Health and Care Bill. The RCN has sought to address as much as possible in this submission, but given the complexity of the Bill, we reserve the right to return with additional areas of consideration, concern, and opportunities.

2. Executive Summary

2.1. The RCN is supportive of aims to enable greater integration, reduce bureaucracy and put population health at the core of all decision making within health and care. However, there are a number of areas of the Bill which do not provide sufficient assurance pertaining to nursing and patient safety issues. We set out here the implications across key areas of concern, and the requirements our members have determined must be met by the Bill by the time it passes into legislation.

2.2. The Bill must include provisions for Secretary of State (SoS) accountability for assessment of health and care workforce demand, as well as overall accountability for workforce planning in England.

2.3. There are also further areas which will need to be addressed through secondary legislation and guidance. In particular, the role of nursing leadership in and across health and care reconfigurations such as in the new ICS structure, and the input of nursing expertise at all levels of planning and delivery.

2.4. The Bill must not allow for the nursing profession, as a safety critical profession, to be removed from profession-specific regulation.

2.5. No aspect of the Bill must be able to detrimentally affect the existing agreement mechanisms for pay, terms and conditions of health and care nursing staff.

3. Accountability for workforce planning and supply

3.1. There is a clear evidence base that staffing levels have a direct impact on the safety and quality of patient care, as well as co-morbidities and mortality. The current Clause 33 related to workforce planning does not go far enough.

3.2. At the moment, in the context of widely reported vacancies in health and care, there is no shared credible system understanding of workforce shortages and of the increasing demand in both population and service. It is not acceptable for nursing staff to be required to practise in

this way or for patient safety to be compromised so severely. Persistent, systemic workforce issues put nursing staff and patients at risk. Without true accountability within government, the RCN considers the current approach to be a false economy propping up an unsustainable system. This includes a risk of excess spending on agency staff and potentially disproportionate international recruitment to try and meet required staffing levels for safe and efficient care.

3.3. The SoS (HSC) should have explicit legal accountability, through a duty, for workforce planning and supply, as part of service and finance planning, to help ensure staffing for safe and effective care on an ongoing basis. To discharge this duty successfully, there is a requirement for accountability, transparency and scrutiny around the extent of workforce needs now and in future. This must be demand-led, based on service and population need, reflecting the RCN Workforce Standards.[1]

3.4. For workforce planning, there must also be an explicit duty on the SoS (HSC) to produce a strategy for a sustainable health and care workforce, which must include health and safety aspects of workforce planning, as well as preventing inequalities within the workforce. The approach to producing a strategy nationally and locally should build on any relevant models already in place, to both understand and address workforce requirements. Clause 33 of the Bill must not over-write any existing duties on organisations or providers to publish workforce data.

3.5. The RCN asks that the following two amendments are made to this Bill.

3.6. ***Accountability for workforce planning for insertion into Clause 33, on page 40, after line 11***

3.7. 'The Secretary of State must hold explicit accountability for workforce planning and supply, as part of an integrated approach alongside service and finance planning, to ensure that the health and care workforce skills and numbers are sufficient for safe and effective staffing levels in health and care. As part of this duty of accountability for planning and supply, the Secretary of State must produce a strategy for a sustainable health and care workforce. The strategy must:

a) ensure appropriate Government workforce planning, including equality impact assessments, and application of lessons learned from formal reviews and commissions into incidents, to ensure that the workforce is properly protected in the workplace;

b) identify measures to promote retention, recruitment, remuneration and supply of the workforce;

c) take into account the wider health and care labour market;

d) include regard for, and the promotion of workforce health and safety, including provision of safety equipment and clear mechanisms for staff to raise concerns without fear of retribution.'

3.8. ***Accountability for assessment of workforce demand, for insertion into Clause 33, on page 40, after line 15***

3.9. 'The Secretary of State must publish an independently verifiable population needs based assessment of upcoming health and social care workforce demand in health and care.'

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[1] RCN Workforce Standards | Publications | Royal College of Nursing

The assessment must:
a) be based on the projected health and care needs of the population across England for the following 1-5 years, 5-10 years and 10-20 years;
b) be undertaken at least every 2 years in response to changing population needs;
c) be developed in collaboration with key stakeholders across the sector, including employers, providers, trade unions and royal colleges;
d) take full account of workforce intelligence, evidence and plans from providers and partners within integrated care systems;
f) be fully available in the public domain in an open and transparent manner;
g) be verified by an independent body with the relevant expertise
and
h) take full account of all publicly funded health and care services, regardless of provider, including social care and public health.

4. The NHS Payment Scheme

4.1. The proposal to introduce a New Payment Scheme is based on a stated intention to provide greater flexibility to reflect local factors, and to support better flow through care pathways. The RCN is mindful that current payment systems can act as a disincentive to early intervention and timely discharge from acute settings because trusts are paid for activity rather than outcomes. The RCN supports the principle of the planned payment scheme for systems to work together for better outcomes.

4.2. However, it is considered that any proposals developed in the new NHS Payment Scheme must not detrimentally affect the existing mechanisms for negotiations on pay, terms and conditions for health and care staff. Professional bodies and trade unions must be consulted by NHS England/Improvement on the new NHS Payment Scheme. Nursing leaders specifically must be involved in its design. Any staff commissioned for NHS, public health and social care services across pathways should be in receipt of pay, terms and conditions which are at least equitable with Agenda for Change.

4.3. It is vital that payments for health and care services recognise the true cost and 'value' of nursing and reflect RCN Nursing Workforce Standards, in order to meet the needs of, and to protect, the workforce, patients and the public; and that they enable rather than hinder, continuity of care. They must capture unrecognised and unresolved elements of nursing contribution across care pathways (including community provision). We note that the previous Payment by Results scheme failed to do this sufficiently, and as these issues remain unresolved, they must be addressed by any new scheme. Payment levels should be based on transparent economic modelling, to allow sense checking and scrutiny.

4.4. The RCN asks that the following amendment is made to this Bill - ***Consultation on NHS payment scheme for insertion in Clause 114C (2), on page 198, after line 35 -***
d) Relevant trade union bodies

5. Professional regulation and standards setting

5.1. The RCN wants to enter a delegated relationship with the regulator, the Nursing and Midwifery Council (NMC), to determine UK applicable standards for nursing education and practice including those for advanced level practice.

5.2. As such, the RCN is seeking an amendment to the Bill to extend the delegation of standards setting functions to professional bodies (such as the RCN), as well as other regulators, as provided for in the Bill. This will gain parity with medical bodies, who already take this role; and enable the RCN to not only set professional and clinical standards but support the expectation of that parity within the nursing profession, as well as assurance of fit for purpose standards developed by the profession to reflect safe and evidence based contemporaneous practice and ambition.

5.3. The power to remove a profession from regulation should never be applied to a safety critical profession, such as nursing. The Bill must not allow for the removal of profession-specific regulation for nursing. Regulation of nursing must not be "diluted".

5.4. Since 2007, the RCN has called for the mandatory, statutory regulation of all Nursing Support Workers (NSWs). The RCN believes that all NSWs should be regulated in the interests of public safety, and the RCN is committed to supporting steps towards mandatory regulation, in a standard setting capacity. This will become even more important as the needs of the public – being cared for by the nursing support workforce - become more complex, and consequently the need for the complexity of the care provided too will grow.

5.5. The RCN asks that the following two amendments are made to this Bill.

5.6. ***Delegated function of professional bodies in setting standards – for insertion in Clause 123 , on page 105, after line 36***

, or
(c) a professional body for -
(i) a profession to which section 60(2) applies

5.7. ***Delegated function of professional bodies in setting standards – for insertion in Clause 123, on page 104, after line 30***

In section 60 (regulation of health professions and social care workers etc)—

(a) in subsection (1), after paragraph (b) insert—
(b) "(bza) deregulating a profession regulated by an enactment to which subsection (2) applies if the profession is not demonstrated by current evidence to be a safety critical profession in need of regulation for the protection of the public,";

6. Discharge to Assess

6.1. In the context of current high vacancy rates across district and community nursing, and poor understanding of workforce shortages across the health service, public health and social care, along with chronic underfunding due to failure of the current service payment model to recognise community nursing, this legislation should not seek to demand a service delivery approach which transfers such disproportionate risk to nursing staff and patients.

6.2. We agree in principle with the intention to stop delayed discharges. However, without assurance around registered nurse staffing levels, including in social care and/or community settings, which depend upon our proposed amendment on workforce assessment and planning being accepted into the legislation, this cannot be implemented safely given the current state of the system.

7. SoS powers for service reconfigurations

7.1. Currently, decisions are made based on local insight, health expertise and considerations of safety and quality. This is undertaken in partnership with local decision makers and informed by engagement and consultation with local people. Clinical needs of patients should be addressed locally: any change should be supported by full business case, risk assessment, needs of population and not subject to political will.

7.2. The Bill needs additional safeguards to strengthen the centrality of clinical decision making, to ensure that new powers do not undermine care quality and patient safety. Service reconfiguration must enable continuity of care, and not impact negatively through unintentional siloes of care. Placing registered nurse leadership at the centre of decisions will support a whole care pathway approach, and integration of services, where this best meets the needs of people using services.

7.3. The RCN seeks to add our support to amendments that ensure robust checks and balances are in place, including clear processes for local resolution in the first instance; ensuring that there is a clear focus on the interests of patients and the service; criteria indicating when and how SoS (HSC) intervention is needed/will be used; a requirement for the SoS (HSC) to consider local clinical advice and any other advice offered by the affected ICS on a service reconfiguration decision, all of which should be in the public domain.

7.4. The RCN intends to generate support for an amendment to ensure that any service configuration includes an executive Director of Nursing (registered nurse) post. Remuneration for executive Directors of Nursing in ICBs must be commensurate to responsibility and complexity of role, and in parity with other executive Directors in ICBs.

7.5. The RCN asks that the following amendment is made to this Bill.

7.6. ***In Schedule 6 section 38: INTERVENTION POWERS OVER THE RECONFIGURATION OF NHS SERVICES, Power to call-in proposal for reconfiguration, on page 180 after line 44 add:***
(c) seek and take into account local clinical advice with regard to the service reconfiguration including from the local Director of Nursing

7.7. ***In Schedule 6 section 38: INTERVENTION POWERS OVER THE RECONFIGURATION OF NHS SERVICES, Power to call-in proposal for reconfiguration, on page 180 after line 44 add:***

8. Role of commercial companies in health provision

8.1. The driving principles for all health and care service planning and delivery must be quality and outcomes for patients and the public, and that the same standards of quality and transparency for all publicly funded health and care services must be required and adhered to, regardless of sector. Independently provided health and care services must adhere to quality standards and regardless of setting, quality standards must be of primacy.

8.2. There is a significant issue around lack of parity of pay, terms and conditions for employees working in organisations other than direct NHS provision, and an there is opportunity here to seek at least parity across organisations delivering NHS and local authority funded services.

8.3. Further assurance is needed on what process will be used by ICPs to resolve conflicts arising between the interests of patients, taxpayers, and the local population when making decisions about arranging healthcare services.

8.4. There is a potential risk of undue political influence in awarding of contracts or accessing ICBs. It is essential that legislation does not promote the commercialisation of services, or work against the philosophy of the NHS, and to ensure public money is used to provide the highest standard of healthcare and commercialisation compromises this.

9. Nursing clinical leadership in legislated health and care structures

9.1. Registered nurse executive leadership roles must be built into national health and care structures, including a Chief Nursing Officer within UK Government and in each nation's government. Registered nurse leadership is vital to delivering the ambitions of this Bill and the NHS Long Term Plan. Nurse leaders are well placed to understand the health and care needs of their populations and identify opportunities for joining up relevant parts of the patient pathway. It is vital that nursing leadership is represented in all ICS structures, given their unique expertise in developing systems for promoting health and enabling prevention.

9.2. Any clinical roles being legislated for within health and care systems – including ICBs – must include nursing executive leadership roles filled by registered nurses. Nursing leadership should be embedded throughout ICS structures, including within executive and decision-making functions. Registered nurse expertise is critical to ensuring decisions are made in the best interests of patients. The Bill should include statutory roles for nursing leaders on ICS boards.

9.3. The Bill should include an executive director of nursing role (registered nurse) within core membership of every ICB. This would align with the structure set out in the NHS England and NHS Improvement design framework for ICSs which was published in June.[2] Furthermore, the Bill should include a nursing role in list of 'ordinary members' of the ICB.

9.4. The RCN asks that the following two amendments are made to this Bill.

9.5. ***In 'Schedule 1B Integrated Care Boards, Membership: general' 3.1 after line 23 add:***

(c) a Director of Nursing

9.6. ***Amend paragraph 7 (2) 'Ordinary Members' after line 23 add:***
(c) one member nominated by persons who provide nursing services for the purposes of the health service within the integrated care board's area, and (ii) are of a prescribed description; and

(c) one member nominated jointly by the local authorities whose areas coincide with, or include the whole of any part of, the integrated care board's area.

10. Alignment of local authority and NHS commissioning

10.1. Proposed reforms in the White Paper and now the Bill focus almost entirely on NHS bodies and exclude equivalent legal changes for local authorities. Yet there is variation in the level of

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[2] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf

engagement and collaboration between NHS bodies and local authorities in ICSs, and outstanding detail of reforms to social care in England - vital for integration of the health and care system. The exclusion of equivalent changes for local authorities limits meaningful integration of service and workforce planning. We call for reciprocal updates to local authority commissioning of health and care services in the Bill, and alignment in any new payment scheme. This must include alignment in the pay structures and terms and conditions for health and care staff working within and outside of the NHS.

10.2. These requirements must be addressed within forthcoming social care reform, and will require legislation. The Bill does not address the proposed ending of the public health grant which funds several NHS services, such as Health Visiting, School Nursing, Sexual Health, Substance Misuse, Smoking Cessation. It also does not take into account the impact of the pay of staff funded via local authority commissioning and the concept of mandated and non-mandated services. It also does not consider the impact on staff who were TUPE transferred out of the NHS as part of the 2012 reforms. There is an opportunity here to redress the adverse impact that these changes have had.

10.3. The alignment of commissioning structures will not resolve all the issues related to the underfunding of public health and social care. This will require sustained political commitment and bold strategic leadership, supported by increased, sustainable long-term investment that is based on a robust assessment of population demand and the resources, including workforce, required to deliver a world class health and care system that meets demand.

10.4. We will support amendments which seek to align procurement processes within and across ICPs. This must then also be fully addressed through forthcoming social care reforms.

11. ‘Safe Space’ for raising concerns

11.1. We recognise and support the intention of having the Health Service Safety Investigations Body (HSSIB) create a 'safe space' where participants, including nurses, can provide information for the purposes of an investigation without fear that it will be disclosed to others.

11.2. However, giving the SoS the power to remove the ‘safe space’ principle means revealing the staff who have raised concerns. This could ultimately deter nursing registrants from raising concerns, as they are required to do by the nursing Professional Code of Conduct, and therefore impact on whether an issue is reported, responded to and lessons learned. In the context of unprecedented pressures on the workforce, and potential for risk to patients due to systemic issues, a fully safe space to raise concerns is paramount for registrants.

11.3. It is essential to learn from major events such as Mid-Staffordshire, Gosport and Shrewsbury and Telford, ensuring staff are safe and supported in a no-blame environment to raise concerns about patient care and safety. This is part of a demonstrable commitment to the Duty of Candour for health and care services and includes provision of support from Freedom to Speak Up Guardians.

11.4. There are no circumstances not already accounted for by the law that would require for the safe space principle of confidentiality to be removed by the SoS. The RCN therefore opposes this new power for the SoS to authorise disclosure.

11.5. The RCN asks that the following amendment is made to this Bill.

11.6. ***Removal of disclosure of person from whom HSSIB material obtained – remove c) from clause 107(2)***

107 Exceptions to prohibition on disclosure

(2) Regulations under subsection (1)(c) may, for example, require or authorise disclosures of protected material by reference to –

(a) the kind of material that it is (for example, a particular kind of equipment),
(b) the matters to which it relates,
~~(c) the person from whom it was obtained,~~
(d) the purpose for which it was produced or is held, or

(e) the purpose for which it is disclosed.

For any further information regarding this submission, please contact Euan Sinclair Elliot, RCN Public Affairs Adviser euan.sinclairelliot@rcn.org.uk