Royal College of Nursing

Royal College of Nursing response to Proposed changes to the NHS Standard Contract for 2023/24

With a membership of close to half a million 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. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The RCN welcomes the opportunity to propose changes to the provisions set out in the draft NHS Standard Contract for 2023/24.

The changes and our corresponding responses are set out below:

6) Maximum RTT waiting times. (Service Conditions, Annex A)

We intend to amend the maximum RTT waiting time standard from 104 weeks in the 2022/23 Contract to no more than 65 weeks (to be achieved by March 2024).

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:

The RCN is supportive of the intention to reduce waiting times. Patients who receive care earlier have better clinical outcomes. are less likely to experience complications and their quality-of-life indicators are higher[1].

This reduced waiting time, though clinically appropriate, is likely to be unachievable within the current context. There are significant gaps in the nursing workforce, with thousands of nurses leaving the profession every year. This has an impact on the ability of the NHS to meet the current level of demand, and this issue will be exacerbated if waiting times are reduced, because there will be a higher volume of patients in a shorter time period.

Significant additional investment is needed to expand the nursing workforce and provide additional service capacity. In particular, there is a need for additional capacity and support for the community and district nursing workforce, to meet the needs of those waiting for treatment.

It has only been one year since the standard was changed from 52 weeks to 104 weeks. Frequent changes of this nature can cause challenges for service and workforce planning. This is because services may phase their caseloads according to waiting times standards, and when these change the phasing becomes compressed, causing

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[1] Clearing the backlog caused by the pandemic - Health and Social Care Committee (parliament.uk)

challenges for workloads. Therefore, our recommendation is to make this change but do not then change it again in the near future.

7) Four-hour A&E waiting times. (Service Conditions, Annex A)

We propose to amend the four-hour standard for A&E waiting times so that the threshold is set at 76% (to be achieved by March 2024), rather than 95%.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: While we recognise that there are significant service and workforce capacity issues which are limiting providers' abilities to meet this standard, we do not agree that the threshold for patients seen should be reduced. There is strong clinical and academic research which demonstrates the link between the target and positive impacts on patients, particularly those presenting with time-sensitive conditions such as sepsis or strokes[2]. Reducing this target risks patient outcomes.

We do not support the reduction of the threshold for the four-hour standard in A&E, as there is clearly no benefit to patients gained through the reduction. We recommend that the existing target for Four-Hour Emergency Care Standard must remain in place alongside additional quality measures which should be agreed and tested by emergency care experts.

Additional investment in workforce supply and retention is urgently needed to aid capacity. The Four-Hour Emergency Care Standard can increase stress and pressure in the workplace due to workforce shortages. Insight from RCN members supporting A&E settings indicates that the pressure on NHS Trusts to meet the standard has resulted in undesirable behaviour. Indeed, some patients have been given priority for a hospital bed in order to prevent a breach of the four-hour standard, over other patients who may have greater clinical need, but have already 'breached', so not to adversely affect the data reporting. In addition, some patients are moved out of the Emergency Department into unsuitable accommodation, including corridors, to meet the standard. We deem these practices wholly unacceptable.

However, that does not mean the existing standard is not appropriate. Employers and Government must find local and national solutions, particularly relating to workforce, to make sure it is implemented in the way it was intended. This means having the correct whole-system capacity and resources to provide emergency care in a timely manner. It is when capacity and resources are inadequate that inappropriate behaviour manifests.

12) National Infection Prevention and Control Manual (Service Condition 21.1 and Definitions)

The National Infection Prevention and Control Manual was published in September 2022. For Trusts, implementation of the Manual's requirements is mandatory by no later than

[2] A&E waiting times | The Nuffield Trust

Royal College of Nursing

31 March 2024, and we propose to include a corresponding requirement in the Contract. For other providers, the requirement will be to have regard to the Manual.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments:
The RCN has consistently raised concerns regarding use of the word 'mandatory' and 'adoption' in association with the development of a National Infection Prevention and Control Manual (NICM) in England.

Originally developed in Scotland, the RCN has supported, in principle, the need for provision of a national manual to reduce duplication effort and provide consensus on core IPC principles with providers considering any application of additional measures based on local risk assessment/need. The wholesale adoption of a manual developed in Scotland with 14 Boards represents a completely different scenario to that of England with a complex system of approximately 200 NHS Trusts and 17,000 care homes.

To date language used regarding 'mandation' and 'adoption' of the NICM as a requirement of the National AMR action plan has been vague and open to interpretation. The RCN is fully supportive of the principle of having a national manual however there are concerns that the impact of wholesale adoption of the manual and replacement of local IPC policies without a transparent structured national debate may miss opportunities to improve on the experience of Scotland and focus on what is needed rather than already provided. Further exploration in required on the detail regarding how a manual might be implemented/used/aligned/regulated against in the context of health and social care in England. In discussion with a number of experienced members and stakeholders working in infection prevention and control it was confirmed that awareness of replacement of existing policies is low. Further system and stakeholder discussion and agreement is needed before any further implementation of the manual is actioned in addition to a full publicly available impact assessment and implementation plan. The RCN also notes that use of taxpayers' money could be extensive to fund this work given duplication in Scotland and we are concerned that this does not represent best value for money.

16) Maternity and neonatal services (Service Condition 3.13)

We propose to update the wording of the Contract in relation to maternity and neonatal services, particularly in the light of the continuing need for the NHS to respond to the recommendations of the Ockenden Review and the East Kent Report. • These two reports have highlighted the vital importance of ensuring safe staffing levels in maternity services. We therefore propose to add a specific requirement to the Contract for providers of maternity services to have regard to NICE guideline NG4 (Safe midwifery staffing for maternity settings). • We also propose to include a new obligation on providers to comply with the requirements on providers set out in the Perinatal Quality Surveillance Model; this is an important tool for oversight of the safety and quality of maternity services. • Updated guidance has been published on midwifery continuity of carer (MCoC). This confirms that, where an individual provider can demonstrate that it

meets safe staffing requirements, it can continue to use and roll out the MCoC model – but there is no national target or expectation that every provider must deliver MCoC. On this basis, we propose to remove the reference to MCoC from the Contract. • The current 2022/23 Contract requires providers to take forward the recommendations in the Ockenden Review. We propose now to update that with a broader requirement to work, through the relevant Local Maternity and Neonatal System, to implement the requirements of both the Ockenden Review and the East Kent Report. (NHS England's initial response to the East Kent review commits to the publication in 2023 of a single delivery plan for maternity and neonatal care, bringing together actions required following the two reports and from the NHS Long-Term Plan and Maternity Transformation Programme deliverables. We will build a reference to this plan into the Contract in due course.)

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: We are supportive of this proposal and in particular the use of NICE guidance. The RCN has also produced Nursing Workforce Standards which would be beneficial in these settings to support staffing for safe and effective care. We note that it is disappointing that the midwifery continuity of carer (MCoC) requirement has been removed, but we recognise that current staffing shortages make this challenging in many cases. MCoC has value in providing quality care and outcomes, so it is important that staffing shortages are urgently addressed to reinstate this requirement in the future.

20) Workforce Race and Disability Equality Standards (Service Condition 13.6 and 13.8)

The Contract currently requires i) all providers to comply with the Workforce Race Equality Standard and ii) Trusts to comply with the Workforce Disability Equality Standard, in each case reporting to the commissioner annually on compliance. We have reflected that this "comply with" language is not quite suitable for these two standards, where the focus is on the provider improving its overall position against the indicators in the round. We therefore propose to amend the wording, so that there is instead a focus on improvement (through development of provider action plans to improve performance against the Standards) and on transparency (through publication on provider websites of Board-approved annual performance reports and action plans). Existing reporting requirement (both nationally in accordance with national data collections approved by NHS Digital and locally to the commissioner) remain in place.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: We do not agree with this proposal. Our view is that providers should be required to comply with WRES and WDES, and this is sufficient to generate improvement. Compliance with these standards is essential to demonstrate clear accountability, and where required this should lead to local improvements being made. We recommend that the wording remains as it is currently.

Royal College of Nursing

21) Professional Nurse Advocate role (General Condition 5.5)

The Contract has for some time included requirements relating to clinical supervision for midwives, using a system of Professional Midwifery Advocates under the A-EQUIP model. Following successful national roll-out, we now propose to introduce equivalent requirements relating to clinical supervision for nurses through Professional Nurse Advocates.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: The RCN has been developing the National Education Standards for the Professional Nurses Advocacy Programme, although this has not been published yet. Our members have reported inconsistencies in how the programme is delivered and how knowledge and competence are assessed. The new education standards should help NHSE to promote consistency across the learning provision of professional nurse advocates.

In addition, the RCN would encourage the route of accreditation for approved education institutes to ensure all providers maintain quality. We know that Coventry University has independently evaluated the implementation of professional nurse advocacy. Although we have been informed that the professional nurse advocate role has had a measurable positive impact on the well-being of nurses, the findings of this review are yet to be published. We are also keen to encourage NHSE and employer organisations to evaluate the impact of implementing the A-EQUIP model on patient experience, safety, and outcomes.

22) Workforce planning (General Condition 5.7)

The existing Contract requires providers to co-operate with Local Education Training Boards (LETBs) and with Health Education England (HEE) in relation to the provision of education and training for healthcare workers. For 2023/24, we propose to amend the wording a) to add a requirement to co-operate in relation to healthcare workforce planning, b) to delete the references to LETBs and HEE and replace them with references to NHSE, local ICBs and local Trusts and c) make clear that all providers should be approaching workforce planning, education and training and the development and delivery of workforce plans more broadly in a way which supports NHS bodies to deliver their “triple aim” duties (population health, service quality, efficiency / sustainability). These duties have now been formalised in law through the “wider effects of decisions” statutory duties imposed on NHS organisations via provisions inserted by the Health and Care Act 2022 into the NHS Act 2006.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Royal College of Nursing

Comments: The RCN agrees to these arrangements. However, these are only one aspect of the role of the provider in workforce planning. The RCN is clear that the NHS Standard Contract is a crucial lever in holding providers to account on wider aspects of workforce, within their sphere of control. The Standard Contract should therefore specify that members of the corporate board of any organisation are accountable for the decisions they make and the action they do or do not take to ensure the safety and effectiveness of service provision.

The Contract should require that the nursing and support workforce establishments should be determined by the demand for services and the need to provide safe and effective care and should be underpinned by professional nursing knowledge and experience. This should be reviewed and reported regularly and requires corporate board level accountability. The RCN calls for the NHS Standards Contract to require providers to adopt the RCN Nursing Workforce Standards in the design and delivery of their workforce plans.

23) Staff health and wellbeing (General Condition 5.9)

Reflecting the intention behind the NHS Health and Wellbeing Framework, we propose to include additional requirements in the Contract relating to staff health and wellbeing.
• We propose to add a general requirement on providers to promote staff health and wellbeing. Providers will be required to ensure that the issue is addressed in staff appraisals (through "wellbeing conversations") and that staff are made aware of any support services available and are enabled to access those services where needed. • In accordance with published guidance, we intend to amend the Contract so that each Trust is required to appoint a board-level Wellbeing Guardian.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: We agree with this proposal, but there is a need to ensure that sufficient, protected time is allowed to facilitate wellbeing conversations and that this is not just seen as a 'tick box' exercise. In addition, providers need to know what resources are available to their staff. The wording 'where needed' is subjective.

We suggest the wording is changed slightly to: *'We propose to add a general requirement on providers to promote and enable staff health and wellbeing whilst at work. Providers should ensure, as a minimum, that the issue is addressed in staff appraisals and subsequent reviews (through "wellbeing conversations"). Line managers should be aware of the support services available to their staff in order to share information and facilitate access to those services'.*

Alongside these provisions, we also expect provider organisations to adhere to legal requirements for the provision of adequate welfare and safety facilities, including access to breaks, changing facilities and personal lockers, access to sufficient, well maintained and high-quality resources (including PPE), moving and handling equipment.

All employers must make available and fund timely access to confidential counselling and psychological support for all. Employers in the independent sector often lack the

same infrastructure as the NHS in terms of occupational health provision and lack the funding to implement the same initiatives to tackle burnout and improve staff resilience. Staff must be able to self-refer to these services. It is also essential that any barriers that may prevent nursing staff from accessing these services are addressed by government and employers.

Employers should have effective procedures in place to allow nursing staff – including students – and their representatives to raise any concerns in relation to equipment, policies and processes at the earliest opportunity. This includes systems to allow nurses to report when they are understaffed or do not have the right skills mix. Nursing staff should feel able to raise concerns without detriment and should receive timely feedback. Feedback is critical to ensuring that nurses feel supported by their managers and optimistic that change will happen, which is critical to staff wellbeing.

35) Charging of overseas visitors (Service Condition 36.26)
There have been arrangements in place for many years for financial risk-sharing between commissioners and providers in relation to NHS charges levied on overseas visitors. These have been described in guidance (Improving Systems for Cost Recovery for Overseas Visitors) and given effect through wording in the Contract. It is proposed to discontinue these risk-sharing arrangements for 2023/24, and we have simplified the Contract text as a result.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: Charging rules for overseas visitors may impact on nursing staff and other health and care colleagues practising, as in England, staff are expected to identify and refer a person who is liable for NHS charges to an overseas visitor team[1]. Research indicates that reforms to the NHS charging system in England have negatively affected the roles of healthcare staff and may alter the way that staff can deliver treatment and interact with their patients[2].

NHS "triple aim" (Service Condition 4.6)

The 2022 Act has (through "wider effects of decisions" provisions inserted into the NHS Act 2006) established consistent legal duties for NHSE, ICBs and Trusts in relation to the NHS "triple aim" of promoting population health, service quality and efficiency / sustainability. We propose to update the wording of the Contract so that it is fully consistent with these duties as described in the relevant legislation.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: We welcomed the introduction of a shared legal duty when it was originally proposed. We have consistently considered that this an ideal opportunity to include a

[1] Institute for Public Policy Research (2021) Towards true universal care
[2] Institute for Public Policy Research (2021) Towards true universal care

duty for providers and commissioners related to the workforce. Workforce planning, based on an assessment of population needs should be a core component of service design and planning. If not, services cannot be delivered safely or effectively without the right numbers and skills in the right places.

Booking from NHS 111 into A&E services (Service Condition 6.15 and Definitions)

The Contract contains an existing requirement on providers of urgent care services to enable NHS 111 providers to book attendance slots in those services for suitable patients. We propose to update the requirement to refer to the new Booking and Referral Standard, in consequence broadening its applicability so that it applies to providers of A&E services, as well as urgent care services.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: We have concerns that this proposal would lead to additional patients attending A&E and would run counter to attempts to support and manage people outside of hospital. Our view is that conditions which lead someone to attend A&E are not ones which suit booking an appointment; instead, it is likely that individuals with these conditions would be better supported in an urgent treatment centre.

Domestic abuse (Service Condition 32.3.9 and Definitions)

The 2022/23 Contract requires providers to comply with the requirements of the Domestic Abuse Act 2021. Statutory guidance in support of the Act has now been published. The guidance - is designed to help organisations to identify and respond to domestic abuse; • explains the expanded definition of domestic abuse used in the Act (covering a wide range of crimes, including physical, economic, psychological and emotional abuse, controlling or coercive behaviour, 'honour-based' abuse, female genital mutilation and forced marriage); and • clarifies that the Act now recognises children as victims of domestic abuse in their own right, including when they have not themselves suffered any physical injuries. We propose to include a reference to the guidance in the Contract.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: While we are supportive of this change, it is important to note that all areas of healthcare have a safeguarding responsibility to identify and support victims/survivors of domestic abuse (as well supporting perpetrators), however systems and processes need to be in place and resourced adequately to provide appropriate and long-term care/support across the sector. In the context of extensive nursing shortages, staff experience barriers when trying to access training and CPD. This is likely to limit the progress organisations can make in identifying and responding to domestic abuse.

Payment of sub-contractors (General Condition 12.6)

The Contract already stipulates, in accordance with the Government's Prompt Payment Policy, that any sub-contract awarded by a provider must require full payment to be made within 30 days from the receipt of a valid invoice. For completeness, we now propose to add a specific requirement to the Contract for the provider to comply at all times with that requirement for prompt payment in its sub-contracts.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: While we agree in principle with this change, it is important that there is also a mechanism in place to ensure that the use of subcontractors is appropriate. Wherever possible, staff should be retained on permanent contracts of employment. Employers who fail to implement proper safeguards could put their staff at risk of additional costs and precarious working arrangements.

Primary and community mental health services (Schedule 2Aii)

Schedule 2Aii relates to the employment or engagement of Mental Health Practitioners (MHPs) by mental health providers to support local Primary Care Networks (PCNs). These roles, which can be for adults / older adults or for children / young people, are able to be 50%-funded by PCNs through the Additional Roles Reimbursement Scheme under the Network Contract Directed Enhanced Service; the balance of funding is provided by the relevant ICB, as part of its overall payment to the mental health provider. We propose to amend the Schedule, so that it allows explicitly for the agreed number of MHPs, by PCN, to be documented.

Yes – your organisation supports the proposal
No – your organisation does not support the proposal
N/A – the proposal is not applicable to your organisation

Comments: In principle, the RCN supports the employment or engagement of Mental Health Practitioners (MHPs) by mental health providers to support local Primary Care Networks (PCNs). However, we caution against the broad title of 'mental health practitioner' and instead ask that the right professionals with the right skills and knowledge are employed. So, for example, if there is a population/workforce need for a psychologist, peer support worker or mental health nurse, this must be explicit. Furthermore, NHSE must be mindful that Staff and workforce shortages have further pressured inpatient and community services to overcapacity, creating significant delays in care. In addition, gaps in community care are adding to the pressure on inpatient services, with bed availability in many services running close to or above capacity (CQC, 2022).

We caution against mirroring existing services in general practice, where innovation to holistically address the complexity of mental health needs must be promoted. For example, the current policy responses – notably the psychological therapy services developed across England through the IAPT programme – provide valuable support and treatment for many people but do not present a complete solution to the range of challenges that exist in general practice and primary care. Many people assessed as too

complex for IAPT services have rejected their referral to specialist mental health services.

This often leaves general practitioners (GPs) to pick up the pieces by supporting people with needs they are often not trained to manage (Kings Fund and Centre for Mental Health, 2020):

- *Child and adolescent mental health needs that do not fulfil criteria for secondary care services.*
- *Mental health needs among older people*
- *People with long-term mental health conditions discharged from secondary care*
- *People with persistent physical symptoms*
- *Psychological needs of people with long-term physical health conditions*
- *Managing the physical health of people with severe mental illness*
- *People at risk of suicide, but not in contact with specialist mental health services*

Primary care will be an important location for whole-person care. Mental health workers in GP surgeries will be able to knit together support and provide easy-to-access help while upskilling the rest of the primary care team (NHS Confederation, December 2022). To sustainably address the holistic needs of populations, at the right time, in the right place, and in the right way, we call for advanced-level mental health nurses, who are independent prescribers, to work directly within general practice. The unmet needs in primary care are multiple and underpinned by complex socio-political and sociocultural contexts. Advanced-level practice is needed to offer truly holistic and comprehensive care. The ability to hold and manage complex risks is a core component of mental health nursing. It will avoid inappropriate referrals to secondary care and delays in accessing early intervention and treatment (medication, psychosocial interventions, and therapy).

Additional comments:

Workforce
Although we recognise that this contract relates to provider organisations, we note that they are limited in their ability to influence overall workforce supply and retention. The Government, DHSC and NHSE have responsibilities to create supportive conditions within which providers are able to meet their contractual duties.

Duties relating to workforce planning will not be achievable without sufficient investment in the workforce based on an accurate assessment of patient and population need. Furthermore, accountability for workforce planning should not simply sit at the local level and must be accompanied by a fully funded long term workforce plan by government. In terms of ensuring accountability for workforce the RCN has long called for a long-term workforce plan, which includes government accountability for assessment of workforce need, and government legal accountability for workforce planning, specifically for the Secretary of State to be legally accountable for an independently verified assessment of workforce needs, to inform a fully funded

Royal College of Nursing

Government-led workforce plan which the SoS is also legally accountable for. This would ensure that the nursing workforce has the right numbers of staff, with the right skills – including across all pay bands and levels – in the right places, to ensure staffing for safe and effective care.

Appropriate pay, terms and conditions for staff providing services is essential for provider organisations to secure and grow their workforce. Inflation, in addition a decade of real terms pay cuts means that nursing pay has fallen significantly. Westminster's refusal to fund fair pay for nursing is a significant contributor to the recruitment and retention crisis currently gripping the NHS. The UK Government must fully fund a substantial, restorative pay rise at 5% above the rate of inflation for NHS Agenda for Change staff to address the nursing workforce crisis and the long-term reduction in the value of nursing pay.

International recruitment

The RCN is concerned by reports from some internationally recruited members that their contracts contain excessive repayment clauses - in some cases as high as £14,000- if they leave their contract before an agreed period[3]. The RCN identifies a significant risk as the potential for staff to be coerced to remain in exploitative working conditions. The contract should include provisions which explicitly prevent employers from using excessive repayment clauses for their staff, in line with best practice guidance for employers set out in the code of practice.

In many cases members report that employers make attempts to intimidate them into paying these fees, for example through threats of deportation and referrals to the NMC. It is imperative that the contract requires all Trusts to follow guidance set out in the UK's code of practice on the international recruitment of health personnel, which states that repayment clauses must be transparent, proportionate, flexible, and include timeframes for repayment[4].

About the Royal College of Nursing

The RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

For further information, please contact:
Charli Hadden [charli.hadden@rcn.org.uk]

Policy and Public Affairs (UK and International)
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[3] Health and Social Care Committee (2022) Workforce: recruitment, training and retention in health and social care - Health and Social Care Committee (parliament.uk)

[4] Department of Health and Social Care (2022) Code of practice for the international recruitment of health and social care personnel in England - GOV.UK (www.gov.uk)