Royal College of Nursing response to NHS England's consultation on the NHS Oversight and Assessment framework

About the Royal College of Nursing

With a membership of over 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.

Overview

Following the implementation of the Health and Care Act, the RCN has been tracking progress on a number of priority areas to ensure that further devolution of workforce decision-making does not lead to poorer outcomes for staff or patients. Broadly, we have found that there is variation between different Integrated Care Systems (ICSs), particularly in terms of workforce planning.

In 2023 NHS England published the NHS Long Term Workforce plan (LTWP). It was not clear in this plan the extent to which local and regional workforce priorities have been factored into national ambitions and targets. There is no information in the workforce plan about how national ambitions translate into local allocations, or how funding will be divided between national decision-making bodies and the 42 ICSs.

RCN scrutiny of Integrated Care Systems in England

The RCN undertook an analysis of all available ICS Joint Forward Plans, along with publicly shared workforce plans and priorities. We reviewed ICS websites and board papers to pull together a comprehensive picture of workforce planning at sub-national level. We compared the types of information contained in the plans to identify the coverage of local workforce plans.

The majority of Integrated Care Boards (ICBs) do not have specific workforce planning currently in place.

a. Seven ICBs have substantive separate workforce plans, or dedicated sections within their Joint Forward Plans or Integrated Care Strategies. However, not all these plans outline specific actions to increase the workforce, and not all plans specifically reference the nursing workforce.
b. 27 ICBs have limited references to workforce planning within their Joint Forward Plans or Integrated Care Strategies.
    i. Many of these ICBs are developing further plans for publication in 2024-2025.

ii. A number of plans simply contain aspirational statements relating to workforce planning, e.g. “we will grow the workforce to meet our needs” or “we will make the region a great place to work”.

c. Seven ICBs have no published plans, or limited plans with no reference to workforce planning.

In some instances, there appears to be a lack of clarity in terms of the role that ICBs play in workforce planning. Several plans simply refer back to the NHS People Plan or make no reference to independent workforce planning at an ICS level.

The regulatory and statutory requirements for ICBs are unclear regarding workforce planning – this may be causing uncertainty as to how responsibility for workforce planning is devolved under the new ICS structure. Many ICBs appear to still be developing their structure as regards commissioning and planning.

Some ICBs are a lot more advanced in their planning and development than others, risking a lack of parity of outcomes between regions. Some ICBs have fully developed and published workforce plans separate to their Joint Forward Plans and Integrated Care Strategies; some ICBs only have draft Joint Forward Plans available, or do not have them published (e.g. on at least one ICS website, links to plans were broken or the plans simply had placeholder text.)

Across all plans, it is difficult to see what level of workforce modelling is taking place, even in those plans which outline concrete actions. Most plans do not include any data on the workforce needs of the region, and very few plans include specific metrics for monitoring progress, such as Key Performance Indicators.

The pandemic shone a critical light on the pressures facing the nursing workforce. The combination of widespread shortages, increasing levels of demand and rising complexity of needs means that nursing staff are at risk of stress, burnout and ill-health. The Government recognised the need to provide additional health and wellbeing support during the pandemic, however, this funding has recently been removed, despite ongoing high-stress environments, high caseloads and high numbers of vacancies.

Without support for health and wellbeing, the nursing workforce is at risk of increasing sickness absences which would put additional pressure on other staff members.

The RCN carried out a survey[1] of all 42 ICSs seeking information regarding the future of their hubs. We asked ICSs to tell us about their health and wellbeing provision, and their plans for future funding.

The RCN sought to understand whether hubs would continue to receive any funding beyond April 2023, the types of support being offered to nursing staff by the hubs, and the impact of the hubs on staff wellbeing.

A total of 28 ICS hubs provided usable data. Of these 28, 12 hubs are remaining open. Seven of those remaining open have less than a years’ funding remaining, and four of these are funding this from existing budget or an existing underspend.

[1] This survey was undertaken in April 2023.

15 further hubs have closed, and one is uncertain whether it will be able to remain open.

Hubs also referenced the cost savings from staff accessing mental health and wellbeing support. One response noted that 91% of those who accessed the hub (including 33 nurses) said that the support that they received enabled them to stay working in the health and social care sector. The hub noted that as a breakdown of costs, this represented £4,500 spent per member of staff retained, compared to recruitment costs of approximately £396,000 if those staff had had to be replaced. The hub also led to reduced sickness absence, which also resulted in cost savings.

Overarching concerns relating to workforce planning

There is a lack of clear guidance around ICBs' role in workforce planning

From the information made publicly available by NHS England and the Department of Health and Social Care (DHSC), it appears that there is a lack of clarity in the precise role ICBs should be playing when it comes to workforce planning in their region.

There is a requirement that each ICB complete a Joint Forward Plan, and the general intention appears to be that these should include actions for workforce planning. However, this is not a concrete requirement in any available guidance.

Further to this, NHS England's Long Term Workforce Plan makes patchy reference to ICBs, and does not make clear the interconnectivity between ICBs' individual workforce plans and the wider LTWP. It is not clear how NHS England intends to give regard to regional workforce planning in its wider national strategy, nor is it clear to what extent ICBs must follow the LTWP when designing their own workforce plans.

Some ICBs, possibly due to this confusion, have simply referred to the LTWP in lieu of a regional workforce strategy. This may be as a placeholder while further work is carried out within the ICS, but it also suggests that some ICBs may be unsure as to the level of delegation on workforce planning from NHS England.

The RCN recommends that NHS England should develop and publish clear guidance on how workforce planning is delegated to ICBs and set firmer deadlines for all ICBs to develop and publish an actionable workforce strategy. Without this, ICSs run the risk of having no local plan to combat acute workforce shortages and may be left reliant on national-level workforce strategies that do not give regard to particular regional issues or policy levers.

ICBs seem to be deferring their workforce planning

Many ICBs simply have placeholder text in their Joint Forward Plans indicating that workforce planning is still to take place. This could be due to the lack of clarity around their role in workforce planning, but could also be as a result of the requirement to publish Joint Forward Plans within twelve months of the ICBs being established.

While it appears that some ICBs began developing plans prior to their new structure being established by statute, others were clearly unable to take this approach and appear to have worked at pace to publish their Joint Forward Plans. For a number of ICBs, their first-year actions related to workforce planning are simply to develop further strategies.

While this is understandable due to the timeframes within which ICBs have had to develop their Joint Forward Plans, the staffing crisis within the nursing workforce is urgent, and nurses cannot afford to wait up to five years before their ICB develops actions to address it.

The RCN recommends that ICBs are supported to urgently expedite their workforce planning. Potential support could include NHS England issuing clearer guidance on the role of ICBs in planning and guidance on the relation between the Long Term Workforce Plan and regional-level workforce planning.

Workforce planning needs to focus on retention as well as recruitment

Where ICBs have identified actions relating to workforce supply, these actions predominantly focus on recruiting new staff to the regional workforce. While this is obviously a key component to meeting staff shortages, there also needs to be an increased focus on retaining existing staff and improving their working conditions.

Some Joint Forward Plans outline actions to improve working conditions in sections outside of their workforce supply plans, but these actions are often limited to the practical performance of a role (e.g. providing staff with more skills training) rather than staff wellbeing.

Alongside the development of plans to increase staff numbers, ICBs need to take a much greater focus on the wellbeing and working conditions of their existing staff, including by increasing access to mental health support and focusing on equity, diversity and inclusion (EDI) initiatives to improve working environments for staff from minority or marginalised communities.

While these initiatives are often present in other plans from ICBs, it is important to include them in workforce supply planning rather than treating them as separate issues.

Access to health and wellbeing support is crucial for nurses

Nurse wellbeing has been significantly impacted following the Covid-19 pandemic and there has been an increase in ill-health, burnout, reduced working hours and early retirement among nursing professionals.

Evidence demonstrates that registered nurses' exhaustion can lead to emotional and cognitive detachment from work, which can lead to an increase in patient infections and an increase in nurse workload.[2] Nurses working in hospitals with fewer registered nurses per patient were more likely to report higher levels of burnout and intent to leave their job.[3] Nurses are experiencing moral injury through sustained exposure to unsafe working conditions, and this may lead to increase prevalence of PTSD and other mental health conditions within the workforce.

The RCN has previously raised concerns about the closure of the hubs, stressing that the provision of support to nurses is critical to combatting rising rates of suicide, burnout, mental ill health and sickness absence in the workforce.

[2] RCN, "Impact of Staffing Levels on Safe and Effective Patient Care: Literature Review"
[3] Ibid.

Providing wellbeing support represents good value for money

Where nurses are being supported in relation to their mental health and wellbeing, rates of sickness absence and attrition are demonstrably reduced.

The cost of funding access to services such as counselling and talking therapy, as above, are considerably lower than the cost associated with recruitment of new staff to replace those who are burned out, on extended sick leave, or have left the profession altogether.

If hubs are discontinued, alternative services must be provided

The current levels of support being provided in the wake of hub closures is inadequate to meet the mental health and wellbeing needs of nurses. The most recent data on staff sickness from NHS England shows that more than 1.5 million nurse and health visitor days were lost in 2022 due to anxiety, stress, depression and other psychiatric illness – on average, one in every five sickness days were lost due to mental health issues.

The RCN has previously called upon the Government to urgently provide funding for dedicated mental health provision for nursing staff. If the health and wellbeing hubs have not been viewed as successful or effective value for money by the Government, then it is critical that alternative services are provided.

Responses to the RCN's survey indicated that, while some ICSs would continue to offer reduced services or alternative services such as Employee Assistance Programmes and talking therapy, alternative provisions were not consistent across ICSs, and it was not clear that they were provided in all cases. It is crucial that, regardless of which ICS a nurse works within, they have access to quality, timely support for their mental health and wellbeing to enable to them to return to and remain in work.

Responses to consultation questions

What changes would you make to the framework? Please share details below:

The NHS Oversight and Assessment framework should be expanded to include specific provisions on corridor care with a view to eradicating the practice. The following examples would make progress towards mandatory reporting and improved scrutiny.

Use service contracts to restrict and report on corridor care.

Commissioners of services should increase their scrutiny of where and how care is provided, putting safeguards into contracts that there is sufficient provision to meet demand. Care being delivered in inappropriate settings does not represent good value for public money, and commissioners should pay close attention to providers who are regularly using non-clinical spaces to deliver clinical care.

We call upon commissioning bodies to amend contracts for publicly funded services to include specific restrictions on using non-clinical spaces for the delivery of care, and requiring reporting if breaches occur.

In our opinion, commissioners have a responsibility to report trends in corridor care to national decision-makers, so that they can take action on the systemic issues which lead to demand not being able to be managed within services safely.

In the process towards eradication, where cases of corridor care are happening there must be strict protocols in place that ensure that no patients who are seriously unwell, vulnerable (including elderly), or in urgent need of clinical care are placed in areas without adequate staffing or access to facilities. Where they do not already exist, all hospitals must have clear dedicated zones for patients who are well enough and waiting to be discharged and for those waiting to be admitted to a ward.

Capture data to identify trends.

Service commissioners should mandate reporting on instances of corridor care, which will be collated centrally and provided to government ministers at regular intervals. Service providers should be required to collect data about every instance in which care has been delivered in a non-clinical setting, including:

- What type of non-clinical area was involved (car park, corridor, additional patient in a ward bay or other options).
- How many patients were involved.
- The reason as to why care was delivered in this way.
- And what the likely impact on care was, both for patients and staff.

Additional data collection and reporting will allow both service commissioners and national decision makers to identify trends. In turn, this will allow those involved to make changes either up or downstream to resolve any patient flow issues. This will help make progress towards eradicating the practice.

When trends indicate that capacity is regularly above the planned and funded levels, commissioners should work with service providers to find ways in which staffing levels can be increased to reflect the actual level of need.

Establish ‘chair care’ lasting more than one day as a ‘Never Event’.

One of the reasons why care being delivered in chairs has become so widespread is because there are insufficient safeguards preventing it. Within health services, there are a range of issues classed as 'never events’, those which are “serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance”. It is our view that chair care exceeding a 24-hour period should be placed within this category.

When patients are treated for prolonged periods in chairs, rather than beds, their safety, comfort and mobility is compromised. Privacy and dignity are removed. Support for staff in manual handling is often compromised when temporary arrangements stretch into longer time periods; this puts the patient and the staff member at risk of serious injury.

Not only would adding chair care exceeding 24 hours to the Never Events list increase the focus at provider level to reduce it from occurring, but it would also provide a basis for generating system-wide learning about strategies to reduce and ultimately eradicate corridor care, along with other Never Events. We are also keen for statistics about chair

care and all types of corridor care to be published regularly to allow for more transparency and scrutiny. Never Event records are published at least yearly.

More broadly, in regard to workforce planning, ICSs should be required to:

- Urgently expedite delivery of workforce plans, to allow for scrutiny and discussions about additional funding or support.
- Provide evidence that they are working with local staff groups to identify retention challenges, and design interventions to address these issues, alongside efforts to increase recruitment.

We also expect ICSs to make progress towards improving workforce sickness and absence. They should be required to:

- Undertake analysis to understand which local factors are leading to sickness absence and implement measures to address these.
- Implement data collection and monitoring to track rates of sickness absence across an ICS, in order to identify local and seasonal trends and factor these into workforce planning and the provision of targeted wellbeing support.

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