Royal College of Nursing response to NHS England and NHS Improvement consultation on *Building a strong, integrated care system across England*

1.0. OVERVIEW

1.1. We broadly welcome these proposals for the stated intentions to enable greater collaboration between local health and care partners and make progress towards delivering the NHS Long Term Plan in England. We recognise that these proposals are based on learning from early Integrated Care Systems (ICSs), with the intention that learning about good practice is shared and embedded.

1.2. The COVID-19 pandemic has shown that different ways of working are possible, and that some of these can be beneficial in the long term. This includes local data sharing between health and care bodies, better collaboration on decisions about local need and more leadership at local level, particularly relating to public health decisions.

1.3. Alongside the proposed structural changes, meeting these intentions will also require robust, transparent mechanisms for finance and service planning and delivering quality services, nationally and locally. Workforce planning is a core component of service design and planning.

1.4. However, across the health and care system there is a lack of clarity on roles, responsibilities and accountability for health and care workforce planning and supply. This has resulted in fragmented and incomplete approaches. Without defined responsibilities for workforce planning and supply, and appropriate accountability for carrying these out robustly, the levels and skills mix of nursing staff across the sector continue to be jeopardised. Without the right number and skill mix of nurses in all parts of the sector, services cannot be delivered safely or effectively.

1.5. Without intervention, existing health and care workforce gaps will continue to negatively impact upon patient safety, care and outcomes. The health and care service is currently being compromised due to insufficient numbers of staff.

1.6. In September 2019, following the conclusion of the consultation period on the original legislative proposals, NHSE/I recommended that *the Government should now revisit with partners whether national responsibilities and duties in relation to workforce functions are sufficiently clear*[1].

1.7. This proposed update to legislation provides the ideal opportunity to carry this forward. Without this, it is likely that the nursing workforce crisis – and indeed across a range of professional groups - will continue to develop without clear action to enable sufficient workforce and without recourse to hold Government and the

[1] NHS England and NHS Improvement Board meetings held in common (26th September 2019), *The NHS's recommendations to Government and Parliament for an NHS Integrated Care Bill,* Available at: https://www.england.nhs.uk/wp-content/uploads/2019/09/BM19175-recommendations-to-government-for-an-nhs-integrated-care-bill.pdf

range of national, regional and local bodies to account for the supply, recruitment, retention and remuneration required to deliver safe and effective care. Without intervention, existing health and care workforce gaps will continue to negatively impact upon patient safety, care and outcomes.

2.0. RESPONSE TO NEW PROPOSALS

2.1. In response to the specific proposals put forward by NHSE/I, we welcome the intention to enable local decision-makers to come together more easily in providing joined-up services for local populations. Nursing is a profession which routinely works across organisational boundaries and sectors (e.g. public health, health and social care), so we are well aware of the benefits of enabling integration.

2.2. ***Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade? Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?***

2.3. We agree that there are opportunities for sub-national bodies to take a greater role in health and care workforce planning, to support an overall population-need based approach to workforce planning and supply. Our view is that ICSs are well placed to understand local population need, understand the relevant health and care workforce requirements, and communicate this to national bodies, and therefore should have a robust and consistent role in workforce planning.

2.4. However, this can and should only be taken forward within a clear framework that includes national bodies as well. It is imperative that national decision makers have clear role and responsibilities which can be used to enable good workforce planning throughout the system.

2.5. We want organisations to be granted the specific duties and legal powers to deliver relevant workforce contributions aligned with their role and function. Each layer of decision-making throughout the health and care system needs a clearly defined role commensurate to the level and complexity of their responsibilities, so that they can be clear about their functional role in delivering sufficient registered nurses and nursing support staff, and other professions to meet population need, and ensuring those registered nurses and nursing support staff, and other professional groups are in the right place and the right time to deliver safe and effective care.

2.6. We therefore recommend that ICSs be given specific functions or remits related to assessing local population needs, health and care workforce planning and contributing towards the delivery of a national workforce strategy, and within a framework of national workforce roles and responsibilities.

2.7. Currently, the relevant sections of planning guidance for ICS's do not give any explicit steer to undertake this type of workforce planning. Moving forward, as these proposals remove the legal barriers preventing joint working, the requirements of these bodies in relation to the health and care workforce must be made explicit.

2.8. Any expanded powers and autonomy for national, regional and local decision-makers must be balanced with greater accountability and transparency. This must be set out within a national accountability framework for the health and care workforce and enshrined in legislation. Making these responsibilities for workforce planning and supply a legal requirement at all levels will help ensure clear roles and accountability, supporting sustainable and consistent safe staffing levels throughout the sector.

2.9. We agree that Government has overarching responsibility for leading a review of roles and responsibilities for inclusion in forthcoming legislation. However, given that the proposals from the NHS are focused on creating more enabling legislation, it stands to reason that duties to better enable workforce planning, as part of service planning and delivery, would be included in the package of NHS proposals, and for the system and Government to work together to define these.

2.10. Based on our analysis of the current legislation, and the subsequent issues with lack of clarity on roles and responsibilities for workforce, a legal framework should provide clear accountability for health and care workforce supply and planning. This will include specific duties for Government, national bodies, commissioners and providers to make sure there are enough registered nurses and nursing support staff, and other professional groups, to meet patients' needs. Each will be responsible for using levers available to them within their part of the system, for these aspects of workforce:

- Right numbers & skills - Decisions regarding staffing levels for safe and effective care should be based on assessment of local needs, evidence, workforce planning tools, and the professional judgement of senior clinicians
- Workforce strategy - A credible, fully funded strategy for tackling registered nurse and nursing support staff shortages and those in other professions, to meet the whole country's health and care needs
- Workforce planning - Quality assurance of workforce planning within the system for the right numbers and skill mix of registered nurses and nursing support staff, alongside other parts of the workforce to deliver safe and effective services
- Nursing education - Government enabling education of enough nursing students to meet domestic supply needs, as well as investing in learning and development for existing staff, to equip the nursing workforce to meet patients' needs

2.11. At every level of decision making about the health and social care workforce, from Government to any local provider (regardless of sector), any determination about registered nurse and nursing support staffing must be informed by; legislation, Nursing and Midwifery Council requirements, national, regional and local policy, research evidence, professional guidance, patient numbers, complexity and acuity, the care environment and professional judgement. This should inform, and be reflected in, legislation or any secondary guidance.

2.12. The current approach does not identify workforce requirements proactively, but allocates resource based on what remains when other decisions have been taken. Financial resources and expenditure must be in place to fully fund and support the delivery of workforce plans and the provision of nurse staffing for safe and effective care. These requirements should be applied to workforce specifically, and then embedded into broader decision-making on service planning at national, regional and local levels. This should inform, and be reflected in, legislation or any secondary guidance.

2.13. Our members are clear that this opportunity must be taken to address the existing legal and functional ambiguity with regards to workforce which has contributed to the existing and widely recognised crisis. Taking this positive action will allow for workforce planning to be integrated within wider service planning, with the specific focus required to ensure that services can be of high quality.

2.14. This requirement has already been identified in different forms through legislation by devolved administrations in Wales and Scotland. In Northern Ireland, ministers have committed to developing legislation on safe staffing. In England, devolved and fragmented structures of the commissioning, funding and delivery of health and care services create much room for ambiguity which is reflected in the actions of national and local players across health and care. This legislation is the opportunity to address this fragmentation by implementing clear roles, responsibilities and accountability for health and care workforce planning and supply.

2.15. We note that the Royal College of Physicians stated in their response to the Health and Social Care Select Committee inquiry on the NHS legislative proposals that there should be 'a specific duty for the Secretary of State for Health and Social Care to ensure that there is sufficient workforce to meet the needs of the population within health and care services, accompanied by clear roles and responsibilities for NHS arms-length bodies to enable a funded workforce strategy'.

2.16. We also note that the Royal College of Psychiatrists stated in their response to the Health and Social Care Select Committee inquiry that they "support the proposal by the Royal College of Nursing to give greater legal clarity on where responsibility lies for ensuring the NHS has the workforce it needs". We welcome this position.

2.17. Other stakeholders also recognise that the current structure for managing the supply of staff is not fit for purpose. The National Audit Office[2] have described it as 'fragmented' and warn that the approach risks incoherence. Their report describes that this fragmentation means national bodies do not have either the information they need to make decisions, or the power to implement them. The NAO sets out that national bodies are reliant upon coordinated efforts with those who have different priorities from them; so in reality there is no coordination.

2.18. These positions demonstrate clear support from other significant professions, and stakeholders, to take this opportunity to clarity roles, responsibilities and accountability for the health and care workforce.

[2] National Audit Office (2016) *Managing the supply of NHS clinical staff in England*

3.0. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

3.1. While we believe that local systems should be given flexibility to suit the needs of their local systems, we are concerned that both proposals are 'NHS-heavy' and do not set out what protections will be in place to ensure that there is clear space and roles for Local Authorities within either proposed ICS structure.

3.2. We also have concerns about the level of nursing representation within the design, leadership and governance of ICSs. Nursing leadership is critical to ensuring that local provision and workforce is able to meet local population needs. National guidance and frameworks for ICS governance should require the representation of significant workforce groups and clinical expertise within the leadership and governance of ICSs. This needs to include medical, nursing and allied health professionals, covering all parts of the health and care sector.

3.3. Experiences during the pandemic have indicated that 'participation' of both NHS and Local Authorities within the same structure does not generate equality in terms of the outcomes experienced across health and care services. An example of this is the redeployment of staff and returning staff which almost entirely went to the NHS, despite huge shortages in the care sector. There must be mechanisms in place to ensure that the needs of all types of health and care provision across local care economies are recognised and prioritised equally within ICS structures. The governance arrangements should facilitate planning based on robust assessments of population health and care needs.

3.4. There must be a clear framework and guidance in place for ICSs, along with national support and monitoring to ensure that systems do not become disproportionately NHS-focussed, to reduce unwarranted variation in quality, safety or level of provision. We think it is important that the independent sector and third sector bodies have the opportunity to be involved in ICSs, and that the governance arrangements should facilitate this.

3.5. The legislation must require that governance arrangements be underpinned by good quality, transparent data collection and reporting from all involved in the ICS. This includes both health and care settings, including the independent sector. Data is critical to facilitating decision making which is based on local population needs and information about the workforce.

3.6. ICSs should also be required to proactively communicating and sharing information with relevant staff-side groups to maintain transparency with the workforce about any changes that could impact their terms and conditions, deployment or service type.

4.0. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4.1. At this stage, without clarity on the 'appropriate safeguards' we are not able to fully support this proposal. We have some concerns that delegating or transferring specialised commissioning responsibilities to ICS bodies from NHSE could lead to inappropriate variation developing at local or regional level. The existing national framework for specialised commissioning puts protections in place against this type of variation.

4.2. We think it is necessary for NHSE to undertake a full impact assessment of the potential options for specialised commissioning at ICS level, and use this as the basis of identifying what safeguards are needed to protect the quality and safety of these services. This information should then be made available for full consultation.

4.3. An impact assessment should also look at what safeguards need to be in place to protect existing services commissioned by NHSE from any adverse impact generated through changes in legislative structures and working arrangements. This includes both the impact on staff groups, service contracts and coverage, and any patient groups who receive support from these services.

4.4. There needs to be consideration and more information about the protection for specialised commissioning funding if it was to be transferred to ICSs. One potential option is for funding be ring-fenced to protect the provision of specialised services.

5.0. CONCLUSION

5.1. We need further assurance that additional responsibilities for ICSs will not lead to unwarranted variation arising in terms of service provision or quality. This will be compounded if ICS structures become too NHS-focussed without appropriate involvement of Local Authorities and others. Nursing leadership is essential to local health economies and as such should be a mandatory part of governance structures.

5.2. Further detail, impact assessments and options are needed relating to the commissioning responsibility for specialised services. This includes information about how the funding will be protected within local health economy budgets.

5.3. Without sufficient workforce across the health and care sector, these legislative changes will not lead to the delivery of the NHS Long Term Plan. If clarified and comprehensive legal responsibilities for the health and care workforce are introduced in legislation, the health and care system would be much better equipped to work together to plan how the workforce can be grown and developed to deliver a comprehensive, quality care service to meet the needs of the population. Without these changes, the workforce crisis is likely to continue, with patients facing greater risk to their safety, experiences and outcomes. In the aftermath of the pandemic, these duties are especially important to stabilise the workforce. This will put the health and care system in a position of readiness to meet future challenges.

5.4. It is clear that the ambitions of the Long Term Plan can be realised only by resolving now who must be accountable and responsible for the actions we have described. It is critically important that Government and each player in the health and care system is fully clear on their accountability for health and care workforce-related duties so that all can be confident about meeting the health and care needs of the population, now and in the future.

Appendix A

6.0. RESPONSES TO THE SPECIFICS SET OUT WITHIN EXISTING PROPOSALS

6.1. In 2019, NHSE/I published specific legislative proposals to which we responded to. NHS England has stated that "*These recommendations were strongly supported and backed across the health and social care sector. We believe these proposals still stand*". We broadly support the proposals but there are some areas where we required further assurance or clarification. We have therefore copied our positions on the proposals below to support NHSE/I in the further development of their legislative asks, to take into consideration when making recommendations to Government.

6.2. The proposals set out in 2019 by NHSE/I describe intentions which we welcome in principle. However, they require either expanding to include specific workforce duties, or the provision of further assurances to mitigate against unintended consequences.

6.3. Shifting from competition to collaboration: This is the proposal that mergers involving NHS Foundation Trusts would no longer be overseen by the Competitions and Market Authority (CMA).

6.4. We welcome the intention of these proposals, and anticipate that the role of NHS Improvement in this process will be sufficient, whilst avoiding expense and bureaucracy. Given the impact that these changes could have upon the registered nurse and nursing support staff workforce, we believe it is necessary for registered nurses and nursing support to be consulted on the development of plans. This is especially important if any local merger leads to a situation in which there are requirements for staff to move across multiple sites, or across a larger footprint.

6.5. Getting better value for the NHS: This is the proposal that existing procurement regulations be revoked and replaced with a 'best value test'.

6.6. We welcome the intention of this proposal and believe that it would reduce lengthy and costly bureaucracy. However, further clarity and detail is needed on the 'best value test'. Alongside the component parts set out in the proposals, we seek assurance that the 'best value test' includes specific consideration of whether NHS Commissioners are obtaining best value from their resources in terms of:

- Active consideration of relevant issues in making any decisions, with explicit regard to local population needs, patient outcomes and workforce issues;
- The delivery of high-quality nursing practice, and in the delivery of safe and effective care;
- Patient choice and patient safety;
- The likely impact on the workforce and their training and development requirements, and on any recruitment or retention strategies which are underway.

6.7. Our recommendation is that implementation and guidance should be based upon a nationally agreed and evidence-based 'best value' framework, and that a clear

mechanism is developed to assess the impact of this. We recommend that a nationally-agreed 'best value framework' should be commissioned to support these proposals. This framework should include the requirement that short, medium and long term workforce plans are developed, with phasing to demonstrate how this would be implemented. Development of 'best value' approaches should involve clinical and patient groups, and take into account the current evidence base, as well as wider systemic issues and priorities.

6.8. In terms of developing this framework, we have previously created assessment criteria for the workforce elements of service redesign or change[3]. These questions may provide a useful starting point for the framework:

- Is there a clear workforce plan – and has this been integrated with financial and activity plans?
- Is the proposal making most effective use of the workforce for service delivery and is it compliant with all appropriate guidance?
- Has the proposal considered any training and development needs for the existing workforce to meet the proposed service delivery?
- Is there any consideration for implications for future workforce?
- Have staff been properly engaged in developing the proposed change?
- Is there evidence of staff consultation and analysis of risks and mitigation actions?

6.9. Senior registered nurses have described trends in which contracts tend to be awarded to 'the cheapest' service provider, rather than necessarily the one which will provide the most comprehensive care. It is important for legislators to consider what type of national mechanism should be in place to provide independent scrutiny over the decision making process based on quality and patient outcomes. This should include clear safeguards to ensure that procurement does not allow services to provide remuneration below Agenda for Change structures, which should serve as a minimum pay offer.

6.10. Our members have already highlighted previous 'best value' approaches to procurement, which should be learned from in developing a new version. In particular, members have brought attention to the Local Government Act 1999, which set out conditions for local authorities to make decisions based on an assessment of best value. The Audit Commission provided oversight for the initial implementation of this approach. However, members have raised that since the dissolution of that body, many local authorities shifted away from attempts to comply with their duties in this way.

6.11. Given this example, it would be prudent to hold the implementation of this proposed best value test 'under review'. This would give regular opportunities to assess the impact of the test upon decisions. This would allow for data trends to be monitored,

[3] Royal College of Nursing (2018) *Reviewing and Assessing Service Redesign and/or Change Proposals – RCN guidance.* [https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2018/may/pdf-006911.pdf]

particularly patient outcomes. The review mechanism should include clear opportunities for relevant parties, including providers, staff representative groups and the public to raise concerns, and for these to be taken into account. These reports should be responded to appropriately locally, and collated nationally and made publicly, so that policy makers can identify themes within the concerns raised, and consider any necessary systemic response.

6.12. Our members have also pointed to examples where contracts have been awarded to providers without relevant clinical expertise, for example the Health Visiting and School Nursing service in Slough[4], which was awarded to a smoking cessation provider. Concerns have also been raised that this aspect of the legislative proposal, combined with the creation of joint provider and commissioner committees, may undermine truly independent assessment of 'best value'. It is critical that the best value test includes safeguards to ensure that providers are able to demonstrate sufficient expertise in delivering the required services, and in managing clinical risk, and that concerns can be raised and independent scrutiny provided.

6.13. These safeguards may include:

- Setting minimum standards for key conditions
- Ensuring appropriate expert clinical input to decision making
- Ensuring effective consultation with both patient groups and advocates for vulnerable patient groups including children; patients with learning disabilities and the elderly

6.14. Increasing the flexibility of national NHS payment systems: This is the proposal that national tariff prices be set as a formula rather than a fixed value.

6.15. We welcome this proposal based on its intention to provide greater flexibility to reflect local factors, and to support better flow through care pathways. We are mindful that current payment systems can act as a disincentive to early intervention and timely discharge from acute settings.

6.16. Integrating care provision: This is the proposal that the Secretary of State would be able to set up new NHS Trusts to deliver integrated care ('Integrated Care Providers' where one contract is used for multiple services together)

6.17. We have consistently been supportive of the stated aims and underpinning objectives of sustainability and transformation initiatives across the health and social care system in England but we have previously raised concerns about how this has been applied in practice. Given the potential impact of integration on the delivery of safe and effective care, scrutiny and assurance is required at every stage. Any changes which could lead to negative impacts on patient safety, outcomes or experience must be avoided.

[4] https://www.nursingtimes.net/news/community/exclusive-nurses-raise-concerns-over-new-private-contract/7020553.article

6.18. An Integrated Care Provider (ICP) is an organisation which holds a single contract for multiple services. The aim of this is to give one lead provider responsibility for the integration of services for the local population, specifically to enable integration of primary medical services with other health and care services.

6.19. The formation of ICPs could potentially lead to changes for staff in terms of working across sectors or across different settings. These changes could offer welcome opportunities, such as more autonomous working. However, the introduction of providers who have a broader remit could result in the prioritisation of financial efficiencies, rather than quality, across services. Unchecked, this could result in poor workforce planning to ensure the right people, with the right skills, are in the right places to meet the needs of patients. This in turn could further result in unsafe staffing levels and skills distribution to provide the care patients need.

6.20. Therefore, any moves toward greater responsibility and autonomy must therefore be matched with greater accountability, transparency and scrutiny. ICPs should therefore only be formed if it can be demonstrated that there will not be an adverse effect on the pay, terms and conditions of any staff involved, and that their plans promote patient safety and the delivery of safe and effective care.

6.21. If the Secretary of State for Health and Social Care is given legal duties to create new integrated NHS Trusts, there need to be safeguards to ensure that decisions about the health and social care workforce, from Government level to local provider are informed by a range of credible data and evidence. Any determination about staffing must be informed by legislation, Nursing and Midwifery Council requirements, national regional and local policy, research evidence, professional guidance, patient numbers, complexity and acuity, the care environment and professional judgement. There must be a mechanism for transparency and scrutiny of these decisions, as well as ensuring that opportunities for data collection and reporting are enhanced, and not diminished, through structural changes to providers.

6.22. There are a number of components which should be included as part of the mechanism for scrutinising decisions, for example:

- Delays/bottle-necks between different parts of the service(s)
- Clinical effectiveness – the type of scrutiny will depend on the services under contract – but should include external scrutiny from peers, professional bodies and regulators
- Effective incident reporting and learning mechanisms
- Patient experience – scrutiny by bodies such as Healthwatch

6.23. We also seek reassurance that increased deployment of the ICP contract will not lead to a diminishment of the nursing voice or leadership role within services, as they come together under one contract. Therefore, opportunities for nurse representation and staff-side discussions should be promoted, and executive nurse posts should be protected.

6.24. We note that experiences of the first ICP contract with Dudley CCG has come up against a number of challenges in the procurement process. Board minutes highlight the risk of ongoing delays in the process to staff members[5]. The report stated that 'staff who deliver the services would become more unsettled' as the process took longer than expected. This indicates that there is a need for further development of the contract and implementation process before there are attempts made to roll-out further. This is necessary to provide stability for staff delivering services. We are continuing to consult with our members and staff across England to test this initial position.

6.25. Managing the NHS's resources better: This is the proposal NHSI be given powers to direct mergers where there are clear patient benefits, and set annual capital spending limits for Foundation trusts.

6.26. Under these proposals, NHS Improvement would have expanded powers to direct mergers or acquisitions involving NHS foundation trusts where there are 'clear patient benefits'. Further clarity and detail is needed as to how patient benefits would be quantified and measured. This should be expanded to take into consideration the wider contextual factors involved in mergers, such as the impact upon nursing staff, pay, terms and conditions, and upon ongoing recruitment and retention strategies.

6.27. Shared responsibility for the NHS: This proposals is the introduction of a new shared duty for CCGs and Providers to promote the 'triple aim' of better health for everyone, better care for all patients, and efficient use of NHS resources.

6.28. We welcome the introduction of a shared legal duty. We consider this an ideal opportunity to include a specific legal duty related to the workforce, through expansion of the proposed duty. Workforce planning 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.

6.29. Planning our services together: This is the proposal that groups of CCGs be given the ability to collaborate to arrange services for their combined populations

6.30. We welcome this proposal, and recommend that these arrangements also be expanded. There should be explicit duties for CCGs entering into joint arrangements to understand local needs and plan workforce to meet this need, and this requires local collaboration. They should be responsible for escalating concerns about workforce and data gaps into the system. They also need responsibilities for delivering clear objectives as part of national workforce strategy. With these responsibilities, they should be accountable for enabling providers to design and deliver services with the workforce they need to ensure safe and effective care.

[5] Dudley CCG board papers, November 2018, available at http://www.dudleyccg.nhs.uk/board-meeting-dates-and-papers/

6.31. *Joined-up national leadership: This is the proposal that NHSE\I merge, and that the Secretary of State for Health and Social Care be given powers to transfer functions between ALBs, or to create new functions for them.*

6.32. We broadly support the intention of these proposals. Expanding powers for the Secretary of State for Health and Social Care provides a clear opportunity to articulate the new duties for workforce that we have called to be included in this legislation. Existing mechanisms have proven not to be sufficient for the Secretary of State to direct the system with regard to workforce, as we have set out above. If the frameworks or structures are not able to deliver comprehensive workforce planning, they are not able to produce high quality service design planning.

6.33. We note that there could be potential for conflict of responsibilities within lead national NHS organisation, specifically between system financial pressures and efficiency, and meeting a comprehensive service to meet the health needs of the population. It will be important to understand and gain assurance on the mechanism for transparent decision making and resolution in these types of conflict.

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.

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