Standing up for patient and public safety

ENGLAND POLICY REPORT

RCN Legal Disclaimer

Throughout history, and across the world, the nursing profession has spoken out for patient and public protection and safety. The voices of nursing staff belong in all conversations and decisions, locally and nationally, about patient care. The significant nursing shortage in England ï ʰʱ% vacancy rate in the NHS without counting social care, public health or primary care ï means inadequate staffing levels across all settings. With an over-reliance on temporary staff filling gaps, we know that that the shortage is putting patients at risk and pushing nurses to leave the profession they love due to the pressures they face.

We also know that the long standing and significant issues for nursing supply and planning in England have not yet been resolved, nor long term solutions identified. This is in part due to the complexity and fragmentation of the devolved health and care system. The risk to patients' safety is unacceptable and we are standing up to say that they deserve better. We are reaching out to the public to join us through a public advertising campaign, which we launched on Patient Safety Day (ʰʁth September). While we deeply appreciate and value all the contributions of our colleagues from overseas, it is not sustainable to be reliant upon other countries above growing domestic supply. The pace and scale of growth needed to meet the needs of the population is significant. It is essential that everyone with a role to play is clear about their responsibilities, and what is in their gift to do for the short and long term.

The NHS has recognised that workforce roles and responsibilities need to be reviewed, and that government is best placed to lead this.

Our members know that protecting the rights of patients requires legal duties for all contributors to workforce supply and planning to be set out in legislation. There are opportunities for government to take this forward. The question now is not ǿShould we? î l C 0 nt& ʂ reo

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Despite government rhetoric that there are 'more nurses than ever before', we know that growth of the workforce is not keeping pace with demand for health and care services. In the last year alone for every extra NHS nurse employed there have been an extra 217 admissions*. This is simply unsustainable, and our members have been clear about the impact on their patients, and the risks of an unresolved shortage.

In their recent proposals for the update to th'

While the health and care workforce gap is growing, patient need for care continues to rise. It will take some years to start closing the workforce gap, yet patients need care and nursing staff need support now. In England this gap now stands at over 100,000 vacancies across all the professions in the NHS, with thousands more

Despite a small (r%) increase in acceptances on A-level results day in 2019 compared to 2018, the overall number of acceptances is 8% lower than it was in 2016, the final year of the bursary in England[12]. The RCN is clear that there is a need for at least £1bn additional extra funding every year to incentivise a significant increase in the number of people studying nursing and to support them while they study and for a large increase in workforce development for nurses currently in the workforce, along with an expansion in clinical placements[13]. This will lead to an increase in the numbers of new registered nurses entering the workforce and begin to reduce the scale of the shortages.

The Government has set out an ambitious agenda for the health and care service, with a particular emphasis on care and support in the community. Within the NHS Long Term Plan it was acknowledged that transformation requires investment in order to deliver an existing service whilst also developing the community service offer. The same principles for investment in service transformation should apply to workforce supply and planning to deliver the transformed service. There is currently a lack of clarity on the accountabilities, roles and responsibilities for workforce supply and planning for all those with a role to play in contributing, in Government and throughout the health and care system. This should take the form of clear legal duties and powers which embed workforce planning into service design and finance planning. Securing this clarity

roles and responsibilities, where this is currently ill-defined. This is not therefore embedded in practice or future-proofed. Approaches in which there is accountable decision making related to workforce need to be strengthened and codified in law to ensure that they are hardwired in for future system leaders, as well as addressing gaps.

The Long Term Plan needs the right number of health and care staff in the right place at the right time. It makes sense to clarify accountability for workforce alongside accountabilities for other aspects of local and national service design and planning.

There is a clear opportunity for the Government to address these issues, substantially, in full, and to future-proof our health and care system once and for all. Leaders within the NHS have proposed an NHS Integrated Care Bill [16]. Accountability for workforce supply, recruitment, retention and remuneration – within Government, and throughout agencies nationally, and organisations locally – should be core to this update.

Law alone is not the answer, but as with all

While there are major issues with nearly all aspects of workforce in health and care services, the system has stated that the most urgent challenge is the shortage of nurses[17]. In the NHS in England alone there are now [illegible] vacant posts for what is already funded and in place - the full 'establishment' of around [illegible] registered nurse roles employed by NHS providers[18]. This vacancy figure has increased by more than [illegible]% from the previous quarter. In social care settings the picture is similar: 20% of registered nurse posts have been lost since 2012, and the vacancy rate is around 10%[19].

As an example, some parts of the nursing workforce have shrunk at an alarming rate since 2010 - numbers of district nurses providing working for NHS trusts in the community are down by 40%[20]. This is despite being pivotal to delivering the expansion in community NHS services set out in the NHS Long Term Plan.

The July [illegible] NHS Patient Safety strategy acknowledges the risk which understaffing can have to ensuring patient safety[21]. It is clear that there cannot be safe and effective care without the right numbers of nursing staff with the right skills, in the right place at the right time. All the necessary steps for transparency and scrutiny

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It also presumes that the numbers of those coming in through training are sufficient to fulfill the need within existing services – which they are clearly not, with a vacancy rate of 11% in NHS trusts[25]. Simon Stevens, Chief Executive of NHS England stated that hospitals are una Ɨ Θa ſ ỗ

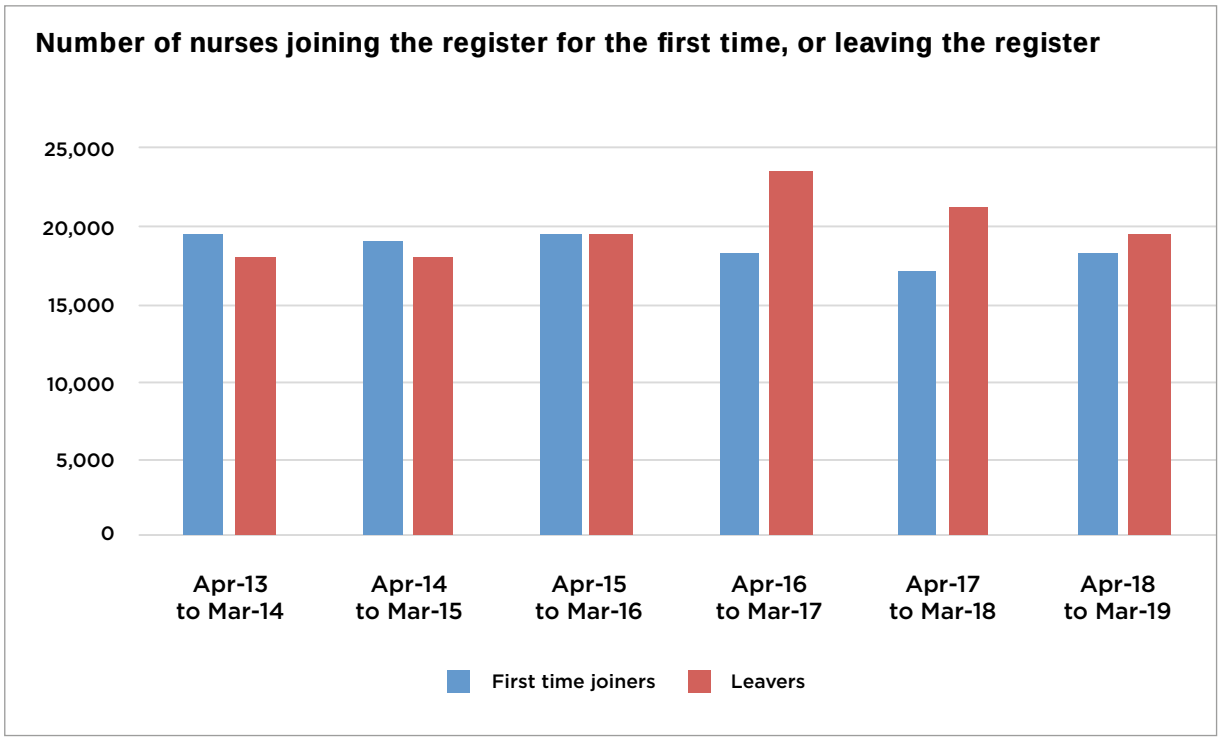

Figure ʃ: Numbers of nurses joining or leaving the NMC register in England

There is a wide range of academic evidence that staffing levels are linked with the safety and effectiveness of their care and their outcomes. This is true in all settings, since insufficient staffing can result in missed care[29]. This issue is one which the public clearly recognise and care about. When surveyed in 2019, 71% of members of the public had the view that "there are too few nurses to provide safe care to patients"[30]. 28% of the public were concerned that they would not get the care that was required when needed, and 16% were concerned the care might not be of a safe standard[31].

Despite the fact that national agencies, regional bodies and local providers consistently raise the impact of shortages, there is no centralised, visible or transparent monitoring by Government or coordination across the health and care system to allow for vital scrutiny into the workforce crisis.

Other parts of the UK have identified the need to do exactly this. In Northern Ireland, the *Delivering Care* framework fCin005C00w 5.83 0arehi

Many of the decisions about the health and care system have been devolved to national bodies, through the Health and Social Care Act (ʰʯʰʰ). In law the Secretary of State has a duty to provide a 'comprehensive' health and care system. This overarching duty, currently held by the Secretary of State, could be interpreted as broad enough to implicitly include workforce. However, without a specific duty for workforce, the Secretary of State does not clearly have the powers to direct the system to address workforce supply or planning, and nor can the Secretary of State be clearly held to account for the role they should play.

Without clear roles and responsibilities for workforce, policy solutions are short term, do not tackle systemic issues, and do not reflect the clear need for sustained investment in supply. The NHS Pay Review Body report states that *"accountability for workforce planning continues to be dispersed across a number of bodies despite the need for system-wide solutions"* [43]. Here we set out the findings of analysis of current workforce roles and responsibilities in relation to each part of the decision-making process.

The Secretary of State for Health and Social Care	
What duties do they have?	**How does this work in practice?**
The Minister has an overall duty in law to provide a 'comprehensive' health and care system to meet the needs of the population.[b] This includes the responsibility to secure improvement in the physical and mental health of the people of England. In undertaking these duties, the Minister must pay particular regard to the effectiveness, safety and quality of health and care services.	There is no specific reference in any legislation which specifies their responsibility to make sure there are enough nursing and other professionals to meet the needs of the population. A recent court case has agreed that the Secretary of Stateîs duties are broad and lack specificity[44].

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Many of the decisions about the health service in England are implemented by 'Arm's length bodies' such as NHS England (NHSE) and Health Education England (HEE). There are issues with lack of clarity and structural barriers between these bodies. In recent months, there have been practical shifts which have been undertaken to align the work of the national bodies, such as collaboration on developing the interim NHS People Plan, and the Government's mandate for 2019/20 to HEE which is aligned to that of NHSE[45]. However, mandates are only a mechanism to describe the activities which a body should prioritise in respect to theio ts0/C219.4 ()C219.4 (pr

The final stage of workforce decision-making is within organisations who receive public money to provide health and care services.

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There are a number of system players and initiatives which make a contribution to supporting patient safety. This includes existing legislation and regulation. We set out here what is in place and why this is incomplete without specific workforce legislation.

Health and Safety Legislation and initiatives

The deployment of appropriate staffing levels is not explicitly referenced in the Health and Safety at Work Act (hswa). It is implicit that many of the duties for employers can only be fulfilled if there are sufficient numbers of staff in place.

For example, employers are required to ensure the health, safety and welfare at work of all employees[48]. In fact, the RCN's staffin7 0xs2133-1.3 (s)5.441 2 16.1 RfW3 Rf th (5.8 (y)0.5 (eo2 1 5)118.6 %)38.9 (o3 (

to patients, as currently all of the supporting elements are in place but the health and care workforce shortage continues to be unresolved.

Overall spending on litigation in the NHS is increasing rapidly. Between 2006 and 2018 payments to clinical negligence claims have quadrupled (from Ãʳ ɥɥm to Ãʱ.ʱbn)[56]. The total cost of all the claims under NHS Resolution in 2018/19 has grown to £83.4bn, an increase of £6.4bn on the previous year[57]. It is more than likely that increasing gaps across the health and care workforce are contributing to increases in errors and missed opportunities, which have devastating implications for patients.

There is a large amount of resource going into improving patient safety and reducing both the likelihood and impact of clinical errors and injuries. NHS Improvement offers incentives for Trusts delivery on key maternity safety actions, and the ȣGetting It Right First Timeȣ programme seeks to improve care by reducing variation[58]. These programmes and initiatives are much more likely to be successful if they are being implemented into health and care settings which are fully and adequately staffed. Staffing for safe and effective care is critical to both avoiding the occurrence of clinical errors and to creating an environment in which patient safety and learning is prioritised. Here, clear accountability for workforce supply and planning throughout the system is the solution which would unlock the ability for the system to transform and improve.

Service regulation

The CQC is the regulatory body for health and care services. Regulation states that providers must deploy enough suitably qualified, competent, skilled and experienced staff[59]

Professional regulation

The Nursing and Midwifery Council (NMC) holds a professional regulatory responsibility, and like the CQC will be aware of many situations in which staff

Our members have set out five principles for legislation enabling staffing for safe and effective care. There are a range of actions attached to each of these:

Accountability - A governance framework that details responsibility and accountability for ensuring an adequate supply of registered nurses and nursing support staff is available throughout the health and social care system to meet the needs of the population.

The Secretary of State for Health and Social Care can:

- lead the debate on roles, responsibilities and accountability for workforce supply and planning within the health and care system, including taking a clear view on what their own role must be
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for public health and social care, including provision for the public health and social care workforces, for workforce growth now and in the future.

HM Treasury can:

- ensure that the NHS People Plan is a fully costed, fully funded workforce strategy which reconciles workforce supply, recruitment, retention and remuneration with population need for primary care, public health social care services, and with government ambitions.

The Secretary of State for Health and Social Care can:

- publish a green paper setting out the options for securing sustainable funding for social care, including growth and development

The Interim NHS People Plan recognises and states that national action

We are calling for a legal framework of accountability for workforce planning and supply which covers all publicly funded health and care services. This includes social care and public health. This will also include the independent sector when they are providing publicly funded health and care services.

The supply of health and care staff into the system is not divided into NHS, social care and public health; there is just one supply line feeding all parts of the health and care system. People are likely to move between settings and sectors throughout their careers, and as services become increasingly integrated. Therefore, this framework needs to cover all parts of the system. This would ensure that determinations about how many health and care staff are required are based upon a robust assessment of need for all parts of the system, not just the NHS. Likewise, reporting on workforce shortages and gaps in particular areas should feed into adjustments made to the supply line.

Clear legal duties in law will help prevent future workforce crises from arising. There are also things needed now to resolve the workforce crisis we are currently in.

A fully costed and funded national workforce strategy for health and care is

Poorer quality care is delivered when shifts have fewer registered nurses than planned

A similar trend was also found in the relationship between those who had a higher proportion of the planned registered nurses on shift and those reporting that the quality of care on that shift as being 'good' or 'very good'. Respondents with fewer than half of planned registered nurses were four times

Care is left undone when shifts have fewer registered nurses than planned

Those respondents with the full complement of registered nurses were also much less likely to report that necessary care had been left undone. Just over a quarter of those with all the planned registered nurses on shift reported that care was left undone, compared to half of those respondents with less than 50% of their planned registered nurses on shift.

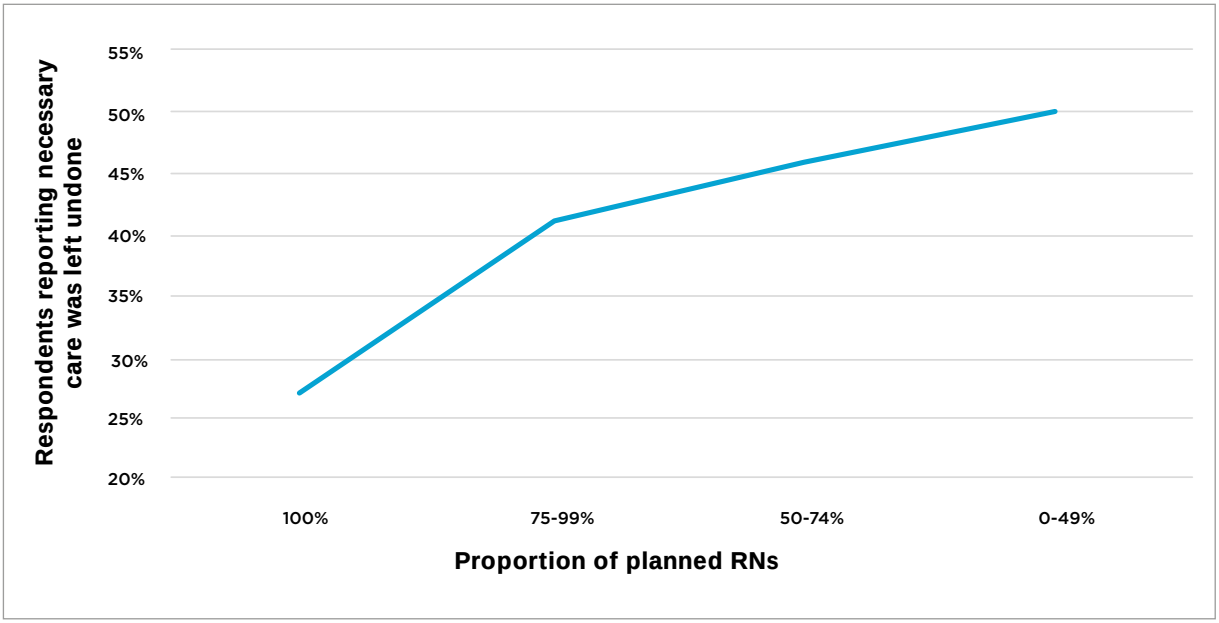
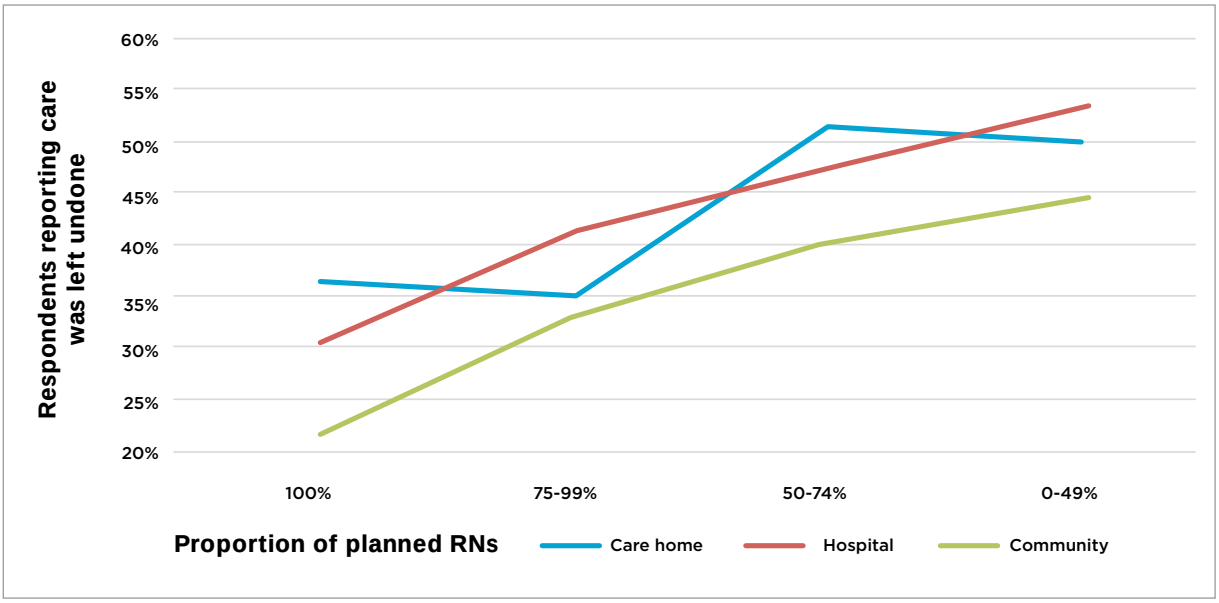


Figure 12: Reporting of care being left undone when shifts have fewer registered nurses than planned in England

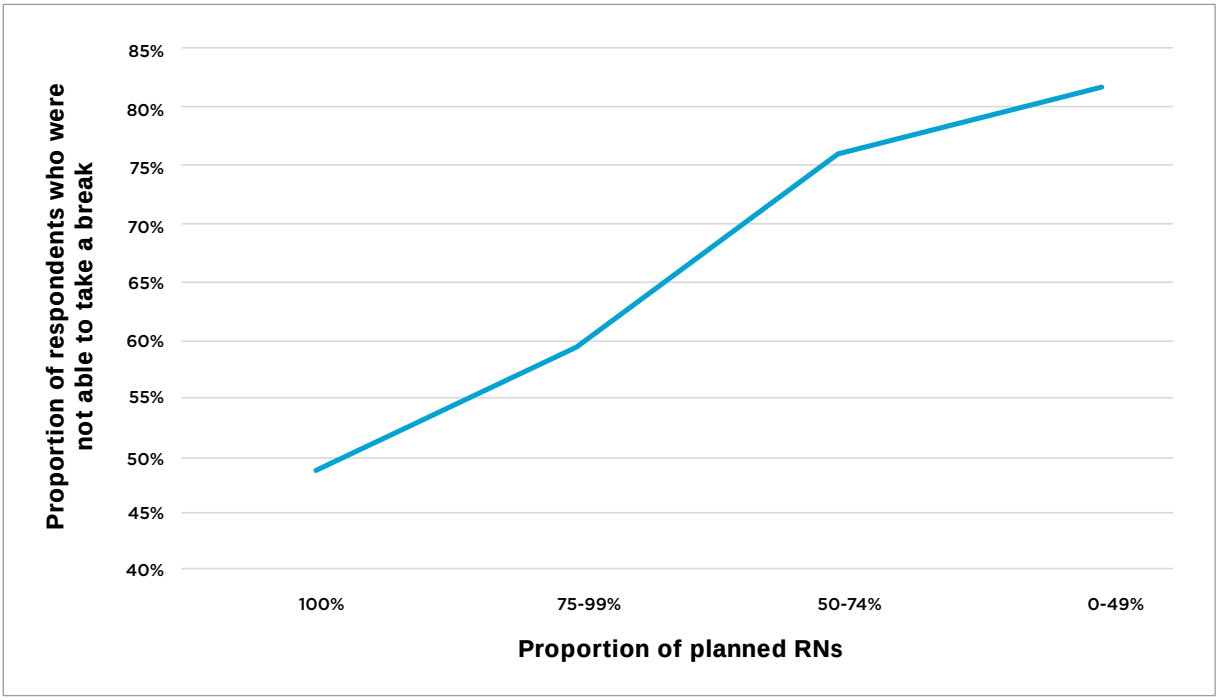
A similar trend was found when comparing respondents from different types of settings. Here, respondents from hospital settings with less than half their planned numbers of registered nurses were more likely to report that care was left undone. There is increasing evidence globally and in the UK through published academic research which confirms this correlation in hospital settings. Research from the University of Southampton found that higher nurse staffing levels are associated with lower mortality in hospital settings[73]. There are several possible reasons for this, including that higher nurse staffing levels reduce the likelihood that care, including vital observations, is left undone.

Early findings from the implementation of staffing legislation in Queensland, Australia show a reduction in avoidable patient deaths and decreases in lengths of stay in hospital when staffing levels are improved[74].



Nursing staff are missing breaks when shifts have fewer registered nurses than planned

There was also a relationship between the proportion of planned registered nurses who were on shift and the likelihood of respondents to be able to take a break. Less than half of respondents with the full complement of registered nurses missed their break, compared to more than 80% of respondents who were missing half of the registered nurses due on that shift.



On average, the respondents with less than half of their planned registered nurses worked 23 minutes more additional time on that shift than their colleagues who had all the registered nurses they planned for. Regularly working overtime can contribute to nursing staff experiencing fatigue, which could lead to an increased chance of errors[79]. It also means that the breaks which staff are getting between shifts are reduced, so staff don't have as much time to recover. This will also impact upon nursing staff with caring responsibilities whose work-life balance is regularly disrupted by overtime. There was also a slightly higher chance of respondents who had all of their planned registered nurses reporting that they were paid for their additional time (hh% were paid) in comparison to those with less than half their planned registered nurses (x% were paid).

1 Royal College of Nursing modelling based on NHS Hospital & Community Health Service (HCHS) monthly workforce statistics, NHS Digital, and NHS Digital data as quoted in House of Commons Library Briefing Paper, Number ꝛɦwh ȷh May ɦɥʰʸ. NHS Key Statistics: England, May ɦɥʰʸ and NHS Digital data on cancelled operations **https://www.england.nhs.uk/statistics/statistical-work-areas/cancelled-**

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