



Royal College
of Nursing

“Our NHS – today and tomorrow”

*A Royal College of Nursing
commentary on the current
state of the National Health
Service and the steps needed
to secure its future*



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Introduction

Since the day it opened its doors, on the 5th July 1948, our National Health Service has improved the health of our nation, transformed the lives of millions and been as much a means of spreading social justice as it has a vehicle for delivering quality healthcare. Noble in conception, effective in practice, this unique institution is the jewel in the crown of our country's public services.

But, almost sixty years on from its creation – and in spite of record, and welcome, levels of investment - our NHS is caught up in a rip-tide of deficit led cuts, rushed reforms and poor workforce planning that is hitting services, hurting patients, undermining staff morale and threatening the hard-won progress made over recent years in raising health outputs, improving clinical outcomes and modernising the delivery of care.

As the professional trade union representing close to 400,000 nurses who care for more than a million patients a day, the Royal College of Nursing (RCN) has an obligation to highlight the areas in which there are real problems impacting upon real services and real people. But we also have a duty to help tackle these problems by developing, and campaigning for, credible alternatives and workable solutions.

This document is a reflection of those twin responsibilities. As such, it is not intended to be an in-depth examination and lengthy analysis of every last dot and comma of government reform proposals, trust finances, patient services or staff issues. Instead, its purpose is twofold. Firstly, to use well researched evidence to shine a light on the areas of most concern, particularly in respect of deficits, and secondly to set out a route map for reforming, redesigning and running our NHS.

Universal, comprehensive, equitable and free at the point of need. These are the timeless values that underpin our NHS. These are the guiding principles that enable it to make a real, lasting and positive difference to every citizen, regardless of who they are, where they live or what they earn.

So, yes, we have to deliver value for money services and ensure financial stability. And, yes, we must modernise, innovate and improve. But, for all of our sakes, let's make sure that we do so in a way that supports and sustains our NHS – today and tomorrow.



Dr Peter Carter OBE
General Secretary
Royal College of Nursing

Summary

Outlined below is a snap-shot summary of our findings, comments and conclusions:

- ◆ the NHS deficits crisis is real and entrenched
- ◆ scarce resources from training budgets and public health budgets are being used to tackle deficits
- ◆ deficits are leading to a serious reduction in the NHS workforce
- ◆ crucial health services are being cut, access to care is being restricted, treatments are being delayed or cancelled and patient care is suffering as a consequence
- ◆ the current short-term cuts should be replaced with a long-term deficits recovery plan
- ◆ there is an underlying shortage of nurses at the same time as the nursing workforce is being cut and nursing workloads are increasing
- ◆ crucial specialist nursing posts are being down-graded and lost
- ◆ close to three quarters of newly qualified nurses are unable to find jobs
- ◆ low pay and low morale are adversely impacting upon nurse recruitment and retention levels
- ◆ nurses are reporting their serious concerns about the state of the NHS to the RCN
- ◆ the NHS is suffering from reform overload with too many rushed, uncostered and untested reforms, redesigns and reconfigurations
- ◆ there is a worrying absence of full and inclusive consultation with stakeholders about reform and modernisation
- ◆ the government has not yet clearly outlined the scope, role and limits of a competitive market in healthcare, nor has it properly debated the implications for the future of our NHS
- ◆ there are question marks as to whether the growing use of the independent sector is delivering extra capacity, value for money or improvements in patient care
- ◆ the progress made in improving clinical outcomes and increasing NHS outputs over recent years could be lost if NHS spending falls after 2008.

1

NHS Deficits

Over the course of the last eighteen months the RCN has invested significant time and resources into tracking, monitoring and responding to the deficits crisis. During this time we have issued regular warnings about the size and the scale of deficits as well as their impact on services, patient care and the nursing profession. We have also consistently called on government and trusts to work with us to solve this crisis.

Moreover, in order to defend health services, safeguard the well-being of patients and lobby for workable solutions to the financial problems facing trusts, we have been engaged in our high profile deficits campaign – “Keep nurses working, keep patients safe” – as well as being leading members of the campaign alliance “NHS Together”.

During the course of our work the RCN has uncovered a variety of evidence showing how entrenched and damaging the current deficits crisis is. Full details of our campaigning activities on deficits can be found at the RCN’s website www.rcn.org.uk/deficits

Deficits are widespread & significant

Deficits are not limited to just a handful of trusts, neither are the trust over-spends small and insignificant. In fact, deficits have spread and they have increased. Although the government has yet to publish its final NHS accounts for 2006-07¹, the latest available figures show:²

- ◆ the number of NHS organisations forecasting deficits has now increased to 35%
- ◆ the number of primary care trusts (PCTs) forecasting deficits has now increased to 47%
- ◆ the gross NHS deficit in England has now increased to £1.318 billion

Training budgets & public health budgets hit

Forecasts indicate that, overall, the NHS is on course for a small net surplus for the last financial year.³ However, this disguises the true scale of the financial crisis facing trusts. In reality the achievement of this small surplus figure is only likely because, over the course of the last financial year, the government has top-sliced strategic health authority funds and diverted resources from essential training budgets and public health budgets.⁴

While we acknowledge that the government has recently announced a decision to reverse this trend we also believe that the top slicing and diverting of funds over the last year poses a long-term threat to patient care and public health.

The threat to patient care arises out of the fact that nurses – and indeed other clinicians – are being denied access to essential training courses. As health professionals, nurses have to keep their skills up to date and have opportunities to learn new techniques to benefit the patients in their care.

Without access to training, patient care is likely to be compromised. But, in an October 2006 survey, the RCN found that:⁵

- ◆ 83% of nurses surveyed believe training has been reduced or cut as a result of financial pressures in the NHS
- ◆ Over 86% of nurses surveyed believe patients are at an increased risk as a consequence of these theses reductions and cuts

Our survey also revealed that:

- ◆ just over 38% of nurses have had study leave cancelled
- ◆ almost 54% of nurses have had a request for continuing professional development training refused

1 Dept of Health has said final quarter figures will be published in May 2007 – see DH press release 28 March 2007

2 NHS Financial Performance Quarter Three 2006-07 (note: these are the latest available figures at the time this RCN document was published in April 2007)

3 Ibid

4 For example, see top slice figures quoted in the NHS Financial Performance Quarter Three 2006-07

5 RCN Training Survey October 2006

There is also worrying evidence which reveals that the number of pre-registration nurse training places has fallen: according to a poll of strategic health authorities in England the average reduction in training places was around 10% although, in some areas, places were cut by as much as 40%.⁶

The threat to public health arises because the use of public health budgets to plug deficits will seriously undermine initiatives to tackle major health challenges such as smoking, obesity and sexual health.

For example, a recent survey by the Terrence Higgins Trust shows nearly two-thirds of PCTs are diverting some, or all, of the funding intended for sexual health services.⁷ In addition, the Association of Directors of Public Health has warned that plans to employ more school nurses, roll out a Chlamydia screening programme for 16 to 24 year-olds and introduce a new system of referral for the overweight have now been shelved.⁸

NHS posts lost

The RCN has been comprehensively monitoring the impact of financial deficits on NHS jobs for some eighteen months. The evidence we have gathered over this period is drawn from a range of sources such as reports from regional activists, information from staff; trust and SHA board papers; and national and local media reports.

Our research clearly shows that NHS posts are being lost as cost savings are made through a combination of:

- ◆ compulsory redundancies
- ◆ voluntary redundancies
- ◆ recruitment freezes
- ◆ deleting vacant posts

The figures are constantly changing as trusts respond to RCN and public pressure, as cost improvement plans roll out and as initial announcements turn into final action plans. However, the impact of the current financial crisis on overall NHS workforce numbers is still serious and we estimate that, as of April 2007, the total number of NHS posts lost across the country due to deficits stands at 22,363.

Contrary to the argument often put forward by the government,⁹ lost posts are not natural wastage. If a post is deleted or a nursing vacancy isn't filled, then that workload will have to be taken up by the nursing workforce in that trust. In other words, the real terms impact on NHS staff, and by extension on patient care, of a post lost due to a recruitment freeze or the deletion of a vacant position is exactly the same as that which occurs when a job is lost through redundancy.

The RCN's picture of NHS posts lost

The table below gives the regional picture of lost NHS posts:

Table 1: Regional Picture of lost posts (source: RCN)

Strategic Health Authority	Lost NHS posts (whole time equivalents)
East Midlands	2,705
East of England	2,540
London	3,628
North East	1,308
North West	1,059
South Central	1,732
South East Coast	2,578
South West	1,769
West Midlands	3,109
Yorkshire and the Humber	1,735
Total	22,363

The RCN has also drawn up a detailed trust by trust breakdown of lost NHS posts (see "Appendix" page 18)

⁶ Nursing Standard, May 2006

⁷ Terrence Higgins Trust Annual PCT Survey, Feb 2007

⁸ See Association of Directors of Public Health <http://www.adsph.org.uk>

⁹ See, for example, comments by Tony Blair MP, Downing Street Summit 12 April 2006

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The RCN's concerns are echoed by others

Our concerns about the impact of deficits on NHS posts are echoed by other stakeholders. For example recent data produced by National Statistics showed a decrease of 11,000 in the number of NHS employees during the fourth quarter of 2006.¹⁰

In its recent report on workforce planning, the Commons' Health Select Committee acknowledged that there has been *"a distinctive change in health service workforce trends"*; that *"the workforce may be beginning to contract"*; and that many trusts were attempting to cut costs and save money by *"freezing or removing vacant posts, by not replacing retiring staff or...through compulsory staff redundancies"*.¹¹

In addition, the NHS Confederation has said: *"the figures being widely quoted of up to 20,000 may turn out to not be too far off the total reduction in workforce numbers this year"*.¹² Moreover, a 2007 survey of NHS chief executives carried out by the Health Service Journal (HSJ) found that 47% of chief executives have declared redundancies while 78% are operating recruitment freezes.¹³

According to the *Health Service Journal* (HSJ), there is even evidence to suggest that the government anticipates a significant reduction in NHS posts. The HSJ has published what it says is a leaked Department of Health document that describes the outlook for NHS staff numbers as *"very volatile"*.

The HSJ states that the document predicts a drop in the NHS workforce of 2.7% this year. With the NHS currently employing approximately 1.3 million people, that equates to a reduction in NHS workforce numbers of 35,000.¹⁴ While the RCN has long argued that the government's workforce planning data needs to be more robust, the figures published by the HSJ do appear to chime with our own findings concerning the impact of deficits on NHS posts.

¹⁰ National Statistics "Public sector employment" Quarter 4 2006

¹¹ Health Committee "Workforce Planning Report" 22 March 2007

¹² NHS Confederation October 2006

¹³ HSJ: "Department of Health NHS pay and workforce strategy, 2008 to 2011" 4 January 2007

¹⁴ Ibid

Patient Care

Deficit led cost savings, together with the loss of NHS posts, have had, and continue to have, a detrimental impact on service provision and patient care.

Services cut & patients suffering

In fact, in a 2006 independently commissioned survey the RCN discovered that:¹⁵

- ◆ 27% of nurses know of treatment delays
- ◆ 60% of clinical nurse managers say they do not have enough staff to give patients the standards of care they would like.

The RCN also analysed responses and information from regional activists, RCN networks, NHS staff and health service user groups which highlighted the following deficit led impacts on patients and services around the country:¹⁶

- ◆ the loss/reduction of access to specialist services such as multiple sclerosis and epilepsy
- ◆ the loss of rehabilitation and intermediate care services
- ◆ the loss of mental health in-patient and day care services
- ◆ a failure to meet 18 week waiting list targets with waiting times of up to 9 months for some diagnostic and specialist services
- ◆ an extension of closure programmes for community hospitals in rural communities
- ◆ the loss of bereavement and end of life services for children and families
- ◆ the imposition of limits on the types and levels of conditions that can be admitted into secondary care via the Accident Emergency Departments of acute hospitals.

¹⁵ RCN "Response to the Health Committee Inquiry into Deficits" June 2006

¹⁶ Ibid

Our findings are corroborated by research undertaken by a variety of other organisations and healthcare stakeholders. For example, in a 2007 survey of NHS chief executives, the *Health Service Journal* (HSJ) found that:¹⁷

- ◆ 50% of Primary Care Trusts are delaying operations
- ◆ 61% of acute trusts are closing wards
- ◆ 69% of chief executives think patient care will suffer as a result of short term financial decisions
- ◆ 73% per cent of Primary Care Trusts are restricting access to treatments

A March 2007 survey by the Local Government Association (LGA),¹⁸ has revealed the severe impact of deficits driven cuts on older and vulnerable people. In this survey of sixty councils:

- ◆ two thirds of councils said NHS deficits were seriously affecting them
- ◆ half of councils said NHS beds had been cut
- ◆ a quarter of councils said there had been a reduction in district nurse numbers.

In its March 2007 annual NHS Staff Survey the Healthcare Commission found that:¹⁹

- ◆ only 45% of NHS staff thought that patients were the top priority for their trust
- ◆ only 39% of NHS staff said they would be happy with the standard of care provided in their trust if they were a patient.

Diabetes UK compiled evidence about the pressure caused by deficits, both on treatment targets and on crucial diabetic related services such as retinal screening.²⁰ While Rethink, the mental health charity, reported that deficit led budget cuts were having a negative impact on existing mental health services as well as posing a threat to plans to introduce modern-age services.²¹

Even the respected House of Commons Committee of Public Accounts has echoed the persistent warnings of the RCN. In its recent report on the state of NHS financial management it concluded that the Department of Health has no clear picture about the impact of deficits on the NHS's capacity to deliver services.²²

Fewer nurses undermines patient care

The impact of fewer nurses can be seen in evidence concerning the relationship between nurse numbers and patient outcomes from a UK study, led by Professor Anne Marie Rafferty. This research – based on a survey of 3984 nurses and 118,752 episodes of patient care in 30 English NHS acute trusts – clearly showed that:²³

- ◆ patient mortality increases where there are fewer registered nurses on the ward (i.e. wards with lower nurse to patient ratios had a 26% higher patient mortality rate)
- ◆ had there been more nurses on the wards, 246 lives could have been saved in the 30 trusts studied. Apply that to the entire NHS and thousands of lives could be saved each year.

The concerns and conclusions of the RCN – and by other key stakeholders in reports – about patient care, were also shared and expressed by the Health Select Committee. Following its investigation into the financial problems facing the NHS the committee published a detailed report in which it concluded that:

NHS deficits "...have affected patient services. Soft targets such as mental health and public health services have also suffered as has funding for voluntary organisations. We believe this to be unacceptable".

Health Committee NHS Deficits Report 7 December 2006, p 79

17 HSJ 8 March 2007

18 LGA survey March 2007

19 Healthcare Commission Annual NHS Staff Survey, March 2007

20 Diabetes UK submission to "Health Select Committee Inquiry into Deficits" June 2006

21 Rethink, "A Cut too Far", November 2006

22 Committee of Public Accounts "Financial Management in the NHS" 27 Feb 2007

23 Prof AM Rafferty "International Journal of Nursing Studies" October 2006

3

Nursing Workforce

The delivery of high quality patient care depends on having a sufficient pool of skilled nursing staff to meet the demands of the service now and in the future. However, although there has been a welcome headcount increase in the number of nurses since 1997, this has been accompanied by an increase in workloads for the entire nursing family as the number of patients treated has risen.

This is compounded by the fact that deficit led nurse redundancies, post deletions and recruitment freezes are having a downward impact on overall nurse numbers – as well as on particular types of nursing posts such as specialist nurses – and, ultimately, on patient care. Consequently, in spite of the recent increase in the nursing headcount there remains an underlying, and worrying, shortage of nurses.

Too few nurses & increasing workloads

The facts and figures listed below show the true extent of the nurse numbers problem characterising the NHS. They also expose the absence of joined up workforce planning on the part of government:

- ◆ there is a retirement time-bomb in UK healthcare i.e. there is an ageing nurse population and it is estimated that 180,000 nurses are set to retire in the next ten years, which means that we will need even more nurses, rather than fewer, in the years to come.²⁴
- ◆ the underlying shortage of nurses is masked by the reliance of the health service on the unpaid work nurses carry out beyond their contracted hours (i.e. 60% of nurses work an average additional 6 hours per week).²⁵
- ◆ the headline increase in nurse numbers in recent years has been accompanied by an increase in nurse workloads as the number of patients treated has risen, but it has not resulted in significant increases in staffing levels in NHS wards (i.e. there was no change in the overall nurse patient ratio on NHS wards for 2005 when compared to 2001).²⁶

Specialist nursing posts hit

The RCN is particularly concerned about the downward pressure currently being put on specialist nursing. Since the publication of the NHS Plan²⁷ nurses have been encouraged to take on a range of extended and advanced roles. These new specialist nursing roles are an integral part of the government's plans to reform the NHS and develop a more patient-centred service.

However, in seeking to reduce costs and balance books, many trusts have targeted these specialist nurses. As a consequence, specialist posts have been frozen, jobs have been lost through redundancy and specialist nurses have been redeployed at lower grades. The end result is, in many instances, an effective down-skilling of the nursing workforce and an undermining of patient care.²⁸

Evidence concerning the extent of the impact of deficits in this area was revealed in a recent RCN survey of specialist nurses.²⁹ The RCN found that:

- ◆ 83% of specialist nurses surveyed said the trust they worked for had a deficit
- ◆ 86% of specialist nurses surveyed said financial pressures were having “an adverse effect” on patient care in their specialist area.
- ◆ 45% of specialist nurses surveyed said they were aware of cuts being made to services in their specialist area.
- ◆ 19% of specialist nurses surveyed said they were currently at risk of redundancy while over 55% said they knew of other specialist nurses in their field whose jobs were at risk.
- ◆ 36% of specialist nurses surveyed said they had been asked to work outside their specialist area to provide cover for staff shortages.

²⁴ RCN “Labour Market Review 2004/05”

²⁵ J Ball, RCN “Managing to Work Differently”, (2005)

²⁶ Op cit, “RCN Response to Health Committee”

²⁷ NHS Plan, Department of Health, London 2000

²⁸ Op cit “RCN Response to Health Committee”

²⁹ RCN Survey of Specialist Nurses March 2007

Newly qualified nurses but not enough nursing jobs

The absence of joined up workforce planning has also been evident in reports that we have received from newly qualified nurses. They are now experiencing difficulties in finding jobs due to planned redundancies, recruitment freezes and the targeting of Band 5 posts in deficit hit trusts. Following a snapshot survey of in October 2006 we discovered that 71% of newly-qualified nurses had been unable to find a nursing position.³⁰

In addition, our survey revealed that:

- ◆ 85% of the graduates still searching for a Band 5 post say they would consider retraining or searching for work in another sector if they continue to experience problems
- ◆ 87% of students believe the current situation will put people off wanting to become nurses in the future.

Our findings are backed up by evidence from the Council of Deans. Their recent survey of employment prospects for student qualifying in summer 2006 shows that less than 20% had secured a post at this stage, compared to 70% or above in previous years.³¹

The impact of deficits is now so serious that, in North Teeside and Hartlepool, newly qualified nurses have been asked to work without pay during their preceptorships while, in County Durham and Darlington, there are reports that they are being asked to work at rates below the national minimum wage.³²

Government forecasts a nurse shortage

At the same time as nurses are being made redundant and nursing posts are being frozen or deleted, it appears that the government is predicting a nursing shortage by 2011. According to the *Health Service Journal* (HSJ) a leaked Department of Health document predicts a shortage of 14,000 nurses within four years – along with a shortage of 1,200 GPs and 1,100 junior doctors.³³

Low pay & low morale

Pay levels are fundamental to the ability of our health service to recruit and retain the skilled nurses needed to deliver quality patient care. Fair pay is also an essential means of maintaining good levels of staff morale. Unfortunately, however, nurses are now the worst paid professional group in the public sector. In fact, nurses' pay has fallen so far behind that:

- ◆ nurses earn 20% less than primary teachers and 24% less than secondary teachers.³⁴
- ◆ nurses with managerial responsibilities earn 14% less than police officers without management responsibilities.³⁵
- ◆ 68% of nurses have to undertake temporary work in order to supplement their incomes.³⁶

In a recently published article the *Health Service Journal* (HSJ) stated that a leaked DH document proposed a number of possible cost-cutting measures by government including local bargaining for nurses and the deliberate use of unemployment to “create a downward pressure on wages”.³⁷ The RCN is concerned about the potential impact of such an approach, should it be adopted, on the pay and the morale of nurses

In the current pay round, the government ignored the Independent Pay Review Body recommendation of an un-staged 2.5% pay settlement for nurses and, instead, opted for a staged deal that equates to just 1.9%. Again, the effect of such a move on morale is likely to be detrimental.

This is confirmed by a recent RCN/ICM survey in which over half of nurses surveyed (51%) rated their morale as either very poor or quite poor, while almost a third of nurses surveyed (29%) said an unsatisfactory pay award would make them consider quitting the NHS altogether.³⁸

30 RCN Survey of newly qualified nurses Oct 2006

31 Council of Deans: “Survey of employment prospects for student qualifying in summer 2006” (June 2006)

32 See Northern Echo, Yorkshire Post, Newcastle Evening Chronicle, 14 Feb 2007

33 Op cit HSJ 4 January 2007

34 Labour Force Survey (January – March 2006)

35 Ibid

36 RCN Evidence to Health Professionals Review Body Nov 2006

37 Op cit HSJ: 4 January 2007

38 RCN/ICM Survey February 2007

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The Voice of Nurses

In recent months, the RCN has received a large number of personal case studies from frontline nursing staff who have witnessed the impact of NHS deficits, rushed reforms and poor workforce planning on patient care.

The testimonies we have received show that deficit led vacancy freezes, redundancies, poor staffing levels and a lack of money to buy the most basic of equipment are affecting patient care and the morale of staff.

Some nurses go so far as to say these problems have caused drug errors and near misses. As such, these issues are putting the health, and the lives, of patients at risk.

All the nurses quoted in this document have requested anonymity. They are concerned that, by speaking out, they could find themselves targeted for redundancy. As one nurse said, *“I am just waiting for the letter to tell me that I am going to lose my job.”*

Below and in the pages overleaf, we have published a handful of case studies which show the fears, concerns and experiences of our nurse.

Our nurses speak out

Nurse A is a deputy nursing director who has been in the profession for more than 30 years, having started as a nurse cadet, but faces compulsory redundancy later this month (March).

The nurse, who works in the West Midlands, says: *“About three weeks ago, I was called to a meeting to be told that my post was at risk. They told me about all the deficits in the NHS, but, to be honest, all that goes over your head.”*

“The reason given to me why I had to go was that because of my level within the organisation, it was highly unlikely that they could find me a suitable alternative.”

The nurse, who was given a month’s notice, believes there are 12 people currently being considered for job cuts at the trust – nurses, training and development people and HR managers.

“Previous to this, there were six senior nurses made redundant in October of last year – six matrons,” she adds. “They had to compete for posts. The feeling of nurses within the organisation is ‘is it going to be us next?’”

“There are a lot of pending reviews happening, especially around senior clinical nurse specialist posts. It is demoralising because I have worked in the NHS since I left school and I’ve worked for this organisation for a long time, working my way up. My colleagues have been extremely supportive, but shocked. Nurses are now very frightened to speak out because they think they will be penalised.”

Nurse B from the north east of England only qualified in January of this year and still has not been able to find work in the NHS as a children’s nurse.

“Towards the end of our training – around November – we were told there might not be any jobs for us at the main trust,” says the nurse.

“Then, just about four weeks before we were due to finish our training, they said, no, there are not any jobs and we wouldn’t know anything until April. In the past couple of weeks, there’s been a couple of positions in the district hospital which I’ve applied for, but there’s going to be a lot of competition for those posts.”

The nurse has heard talk of the local trust having to make 600 job cuts and as staff left the children’s ward areas, they were not being replaced.

“I want to use my skills,” she adds. “My situation is absolutely diabolical. It’s the thought of all that training not being used. Although I’ve got my NMC documents and my pin number, I don’t feel I can call myself a nurse yet because I’m not working as a nurse.”

“To make the decision to do nursing, specialise in a particular kind of nursing and then have to admit you might never get to do it, is absolutely devastating.”

She has a job lined up after Easter as a classroom assistant and has applied for other kinds of jobs such as a family support worker.

Nurse C from the East Midlands is worried that her specialist clinic will struggle to survive as she has been asked to come up with a plan for her staff to spend a fifth of their time in other parts of the hospital.

This specialist nurse has been in the profession for about 15 years. The staff were informed last September the area had a huge deficit that staff at the trust had to help to make up.

“The overspend affected nurses, mainly, in terms of the specialist nurses across the trust,” she explains. “We have been asked to go to areas where normally bank nurses would cover or where there were vacancies that were not going to be filled.”

A request soon followed from management that the nurses come up with an efficiency proposal by May. *“We’ve been asked to give up 20% of our clinical time and use it in a different environment,” she says. “We have worries and concerns about our own competencies within the ward environment, for example we are being asked to work in oncology and haematology – areas that we feel we do not have sufficient expertise to work in.”*

Requests for training to prepare the nurses for this change have been rejected as the trust’s training budget has been cut to save money. Actual redundancies have not happened yet, but staff have been told there will be 200 over the next two years.

“Quality of care and standards are suffering. Sometimes it’s appalling what you see – the speed at which patients are put through the system and the momentum that has to be maintained to get patients in and out of hospital.”

Nurse D from the south west has been a nurse for 25 years and is currently a nurse practitioner at a trust which has had hundreds of redundancies.

“There have been a lot of cutbacks at my trust,” she says. “It hasn’t really affected me directly, but there has been hardship for my colleagues. The staffing levels have been running at what I think are dangerous levels.”

“Where there have been redundancies, most of them voluntary at the moment, they are working at very basic levels of staff which is okay, until somebody goes off sick. They will not use agency staff now and they are working at very low staff levels. They are putting beds in what are not allocated bed spots. They’ve put beds in treatment rooms, which are not properly staffed. There is not an emergency calls systems there.

“I would say the morale is as low as it’s ever been in my 25 years time in nursing. I remember in the 1980s when we last went on a work to rule and I don’t think it’s as bad then as it is now on staff morale and the conditions we are working in.

“Patient care is suffering big time. My father was a patient recently at my hospital and I was absolutely disgusted at the care he got. It’s basic nursing that’s gone because the nurses haven’t got time to do that. We are too busy aiming at targets all the time. You are dealing with the human factor – it doesn’t measure for targets.

“The recent pay rise was the final kick in the teeth for us. All of the hospitals have worked damn hard over the last year.”

Nurse E from the south-east has been a community nurse for more than 35 years and says some nurses feel their professional standards are being compromised because of the pressures on them.

“I enjoy a bit of management as well as some patient contact in my job at the PCT,” she says. “There haven’t been redundancies, but we’ve had posts frozen since the start of 2006. I’ve had one post on my team frozen since spring of last year.

“We manage our own budgets and I actually had money in my budget from the frozen post, but you really have to beg to get bank nurses. Although my budget was in credit, they wouldn’t let me use it to get bank nurses.

“One of my team has gone off on maternity leave and we have got no backfill for maternity leave. They have stopped it. Before, we were allowed 70% of their salaries as backfill, but that’s been stopped.”

This has caused much stress on staff as she adds: *“Myself, and one of my colleagues have been off sick with stress. I was off for three months. There is a lot more stress-related sickness now and very low morale. I’ve been in the health service for all these years and I’ve never seen morale as bad as this. Most of my team would leave if they could find something else.”*

“Quality of care is being affected by the cutbacks,” she adds, saying: “The documentation, for example. The first thing to go is paperwork – it falls behind and is not kept as up to date as it should be. It does have a knock-on effect on patients, although we try not to let that happen, and try not to refuse patients visits.”

Nurse F from the Midlands, is a specialist theatre nurse who has been in the profession for 16 years and fears staff are working to the point of exhaustion.

“In the last 12 months, we have closed three wards and come up with what they call an integrated assessment unit. It’s to shortcut A&E because a patient has to have a bed within so many hours of being admitted to meet targets.

“So what they do is the patient goes to the assessment unit and you can have patients in there for 15 to 20 hours without seeing a doctor and the trust has met the criteria of the waiting time target. On this assessment unit, you can have medical patients, surgical patients, trauma patients and psychiatric patients. That is a fiery mix.”

Posts left unfilled when people have left have been closed at the trust and there have been early retirements. *“Managers are putting tremendous pressure on the nurses,” he adds. “We are now working on minimum staffing levels, but we are under pressure to meet government targets.”*

“Quality of care has dropped – it’s like a conveyor belt. There’s continual pressure on staff. People can’t work under these kinds of pressures – something has to give. Most of my colleagues go the extra mile every day. You work half an hour overtime unpaid and you stop to see a case through day after day after day. This is accepted. Unpaid overtime must amass thousands of pounds each week. They take advantage of our good nature.”

“We are working to the point of exhaustion to get cases done. If I could leave my job, I would go tomorrow. I think 75-80% of my colleagues would do the same.”

Nurse G, from the south west, is a staff nurse on a medical assessment unit who is worried that cut backs have now extended to the drugs that they are able to administer to patients.

“My trust has closed a couple of wards and reduced bed numbers by about 50,” she says. “They have changed things so we have more side rooms. But they have also cut back silly things.” Staff are feeling dissatisfied, as she adds: *“Everyone, bar one, that I have spoken to on my unit wants to move elsewhere. These cutbacks make everything a lot harder because you are constantly scrounging for things and they are being careful with the drug budget.”*

“Now they have got certain drugs which are for named patients only. For other people if they need certain antibiotics, because they are so expensive, we can’t get hold of them and we have to try and borrow them from somewhere else – sometimes we have to call the pharmacists to get them.”

“That could be life-threatening. A person who has got no resistance to infection who has got an infection needs to start their treatment straight away. There are some drugs we just can’t get. Everything now on our unit has got a price on it – literally. When you go to the shelves to get something, there’s a price sticker on everything. It’s at the front of your mind now – money, money, money.”

“There have been cases where I have had to really argue to get something for a patient. I wanted some IV paracetamol for one of my ladies who was terminally ill. The house officer couldn’t prescribe it because the consultant had said it was too expensive. I had to go through the pain control nurse and talk to my registrar and then he gave permission for this one patient to have it. He agreed we could have it in certain cases only. It’s only a bit of pain relief for a terminally ill patient. I shouldn’t have had to argue and fight for it.”

The nurse has applied for a job with the ambulance service as an emergency care practitioner. *“I’ve done that because I am so disillusioned with the whole thing. I am old enough to remember when nursing was about patients first and everything else after.”*

5

The Bigger Picture

The bigger NHS picture is one in which three key factors dominate. The first is the scale, scope and speed of reform. For example, since January 2006 the RCN has received a staggering 138 consultations on everything from Payment by Results to Commissioning a Patient-Led NHS. The RCN's consultation responses, together with briefings giving greater detail about our policy positions, can be found on our website at www.rcn.org.uk

The second factor is the central plank of the government's policy approach – namely a healthcare market in which competition and choice are playing an ever increasing part and having an ever increasing impact. And the third factor is the fast approaching cut in NHS spending as the recent record levels of health care investment fall after 2008.

The RCN & healthcare reform

The RCN has always been the champion of health care reform and modernisation. We are also on record as recognising and praising progress. We have publicly welcomed the extra nurses and the extra investment in the NHS because they make up for decades of shortages, and we have readily acknowledged the significant improvements in patient care.

The RCN is therefore pro-patient, not anti-reform. And, in fact, nurses have been at the forefront of leading and delivering reform. For example:

- ◆ nurses have taken on a range of new prescribing responsibilities
- ◆ nurses have adopted flexible ways of working that have reduced waiting times and waiting lists
- ◆ nurses have taken on new leadership roles, such as consultant nurses and modern matrons.
- ◆ nurses are working as lead clinicians in primary care, in home care support services and in the management of chronic diseases.
- ◆ nurse-led clinics are revolutionising patients' access to quality services.

Without the skills, input and support of nurses, the government's reform proposals would be no more than aspirations. Nurses have transformed policy ideas into practical realities. Nurses are the real change makers.

The RCN believes that, for reform to be effective, workable and sustainable, it must have the input and the support of staff and clinicians, patients and the public, as well as the organisations that represent them. So the principle of consultation over changes to health services matters to the RCN.

We are therefore particularly dismayed by the growing evidence that deficits are causing a consultation dilemma for local NHS bodies. In other words, in their attempts to balance their statutory duty of consultation on service changes with their duty to achieve financial stability, an increasing number of trusts are giving priority to the latter, rather than the former.³⁹

If health care reform is to deliver for patients and for taxpayers then, in the experience of the RCN and the members we represent, it must always be evidence based. If not, then there is a serious risk of unintended and costly consequences that have the potential to negatively impact on patient care and significantly destabilise health delivery systems.

However, the RCN is concerned that, rather than pausing for breath and piloting for evidence, we have reform overload with too many initiatives and changes rushed through and introduced without proper or rigorous testing. We are also dismayed at the absence of the dedicated resources required to fund pilot programmes and develop fully-costed implementation and roll-out plans for new policies.

The Heath Select Committee has supported our position on this issue. In its recent Deficits Report it argued that the Department of Health had a poor track record in forecasting the cost of its policies, on piloting reforms and on local testing of new initiatives.⁴⁰ The Commons' Committee for Public Accounts has also criticised the Department of Health for its failure to properly cost – and thereby fully fund – certain policies and reforms.⁴¹

³⁹ Op cit, "RCN Response to Health Committee"

⁴⁰ Ibid

⁴¹ Op cit, Committee of Public Accounts, 27 Feb 2007

The NHS & the independent sector

The RCN is not ideologically opposed to the use by the NHS of independent sector skills and capacity where it delivers quality patient care and value for money. However, there is an important difference between drawing on the expertise and the capacity of the independent sector in the delivery of NHS care and privatising the NHS by the transfer of its services, staff, assets and resources to private sector companies. The RCN believes that this has the potential to leave the NHS little more than a logo.

The RCN believes that the NHS must remain the centre-piece of our health care system. We would therefore argue that government reforms should be designed to modernise, rather than privatise, our NHS.

Similar concerns about privatisation were expressed by NHS chief executives in a recent HSJ survey. This survey found that:⁴²

- ◆ 22% of NHS chief executives think the introduction of private providers into the NHS will end in privatisation
- ◆ 87% of NHS chief executives think the government is overly impressed by the private sector
- ◆ 91% of NHS chief executives think there is not a level playing field in way NHS and private sector treated

Market based reforms – what’s the end game?

A market-based healthcare system - characterised by increased competition and extended choice - is the centre piece of the government’s reform agenda. However, the RCN is worried about the mixed messages from government about the precise nature, role and limit of the market in the NHS. In our view there has been an absence of proper debate and a lack of clarity about the government’s end game on this issue. For example, in a recent lecture Patricia Hewitt, Secretary of State for Health said: “*where we mean competition, we should say so, instead of pretending contestability is something different. ... why should competition ... be confined to private markets?*”⁴³

By contrast, the Chancellor, Gordon Brown, has made it quite clear that he regards health care as an area of social and public life in which the role of the market should be constrained. He believes the NHS is “*not easily subject to market solutions*” and that there are “*limits of markets in health care for both finance and provision*”⁴⁴

This confusion at the heart of government has been criticised by the King’s Fund. In a recent report they argued that, if reforms were to be effective, ministers needed to clarify the role and the limits of the market as a matter of urgency.⁴⁵ It’s a view the RCN shares.

The market agenda is, arguably, the biggest issue in the bigger reform picture. And, as such, it raises important questions about the future of health care. Questions which the RCN believes need to be properly discussed and thoroughly debated. For example:

1. What should be the limits of the market?
2. How do we balance the ethos of market competition with core NHS values and principles?
3. How do we tackle anti-competitive behaviour and stop the creation of private sector monopolies in a healthcare market?
4. How do we ensure that choice is properly and fully informed; and that it does not undermine equity and universality?
5. How do we ensure that competition does not prevent organisations working together to deliver integrated and seamless care; and that it does not become a crude tool for determining the distribution of services?
6. How do we prevent independent sector bidders for NHS contracts cherry picking “low cost” “high profit” services?
7. How can we ensure that the public, patients, staff and trade unions are properly involved in the process of contracting for, assessing and awarding NHS contracts?

42 Op Cit HSJ 8 March 2007

43 P Hewitt, London School of Economics 13 December 2005

44 G Brown, Social Market Foundation, 03 Feb 2005

45 King’s Fund “Designing the ‘new’ NHS” 05 June 2006

8. How do we maintain transparency and clear lines of accountability when relationships become more commercial, legal and contract based?
9. What mechanisms are in place to ensure that the costs of creating a healthcare market do not result in public funds being diverted from NHS services and NHS patients?
10. What plans and resources need to be put in place to move the appropriate levels of care, staff and services from the acute sector to the community?
11. What is the likely impact of independent sector treatment centres (ISTCs) and the Private Finance Initiative (PFI) on the long-term finances and viability of the NHS?
12. How can we ensure that private sector bidders for NHS contracts abide by NHS pay and pensions, Agenda for Change or NHS terms and conditions for staff?

So there has been welcome progress. But we fear that this hard won progress could be lost, or even reversed. And that's because the level of NHS funding is set to be reduced as a share of national income after 2008. We are concerned that, if this were the case, then spending on NHS services could be hit as might investment in recruiting, retaining, educating, training and developing nursing staff.

Investment & progress under threat

The RCN welcomes the fact that health spending is set to increase to 7.9% of national income in 2007–08. If delivered, this should bring total healthcare spending (including private spending) in the UK to around the weighted average of health spending across EU countries as it stood in 2002. We also recognise that spending in cash terms has doubled from £34.7 billion in 1997–98 to £76.4 billion in 2005–06 and will rise to £92.6 billion in 2007–08.⁴⁶

The large increases in NHS funding have been allocated with the intention of providing higher quantity and quality of care than would otherwise have been possible. In other words, the twin objectives of the extra resources were to increase NHS outputs and improve clinical outcomes. And, with waiting times falling and patients being treated better and more quickly than ever, the evidence shows the extra investment is succeeding on both counts.⁴⁷

⁴⁶ HM Treasury, *Spending Review: Stability, Security and Opportunity for All: Investing for Britain's Long-Term Future*. See also: *New Public Spending Plans 2005-2008*, Cm. 6327, 2004,

⁴⁷ See for example – Office for National Statistics, *Improvements in the Methodology for Measuring Government Output*, 2005

6

RCN Solutions

As the world's largest nursing union the RCN has a responsibility to highlight those areas of health care in which there are real problems impacting upon real services and real people. However, we also recognise that we have a duty to help tackle these problems by developing, and campaigning for, credible alternatives and workable solutions. And that's precisely what we have done with the ideas, suggestions and recommendations outlined below and overleaf.

Tackling deficits

Rather than achieving financial balance through short-term damaging cuts, the RCN is calling for a long-term deficits recovery plan to be implemented which includes the following key components.

- ◆ More time and greater flexibility for trusts to achieve financial balance. This would include creating a centrally funded sustainability (buffer) fund which can be used annually to help achieve balance.
- ◆ Sustainable workforce planning that assesses the long term consequences of short-term actions: we need to end the current culture of vacancy freezes, post deletions and compulsory redundancies and move towards consultation and suitable alternatives.
- ◆ A commitment to clearly identify how services for patients will be improved before hospitals are closed or reconfigured: central to this is proper piloting of new initiatives and open and meaningful consultation with patients, with staff and with the organisations who represent them.
- ◆ Centrally funded pilot programmes and fully-costed implementation and roll-out plans for new policies.

Safeguarding patient care

In order that patients receive the quality care they need and deserve the RCN is arguing that:

- ◆ the government must ensure continued financial support for nurse-led services and nurse-driven innovations
- ◆ health care professionals should be given the time, resources and capacity to help patients make informed choices about their care
- ◆ any proposed cuts to, or variations in, services, should be subjected to a full risk assessment and inclusive consultation process
- ◆ ministers must recognise the role of nursing in tackling the root causes of ill-health as well as the link between social deprivation and public health. Northern Ireland provides an excellent example of how this might work with its "Investing for Health" strategy and the growth in the range and scope of nurse-led services.

Valuing the nursing workforce

Valuing the nursing workforce requires effective workforce planning. The RCN is therefore calling for the following measures, changes and initiatives:

- ◆ the government's workforce planning must be joined-up in a way that recognises the underlying nursing shortage and addresses the severe problems with recruitment and retention of skilled nursing staff
- ◆ ministers should fund and implement pay awards for nurses that reflect the real cost of living, honour the recommendations of the independent Pay Review Body and fairly reward nurses for their skills, dedication and professionalism
- ◆ the introduction for student nurses of a guaranteed one year employment and preceptorship in the NHS. The procedures put in place to ensure that every newly qualified nurse and midwife who wishes to work in NHS Scotland receives an offer of employment are an example of the ways in which this issue can be progressed

- ◆ the acceptance and implementation of Workforce Review Teams recommendations on pre-registration commissions
- ◆ clear Human Resources (HR) standards should be incorporated into contracts with non-NHS providers of NHS services. These should include access to Agenda for Change, the NHS Pension Scheme and NHS pay, terms and conditions. There should also be a mechanism for staff consultation and involvement, a written equal opportunities policy and HR strategy together with an annual staff opinion study.
- ◆ there should be a legally binding duty of partnership – that includes the promotion of quality – between all organisations, public and private/independent, both providing and commissioning NHS services
- ◆ there should be a level playing field between the NHS and private sector companies in respect of tendering for NHS services
- ◆ there should be a clear “failure framework” and a nationally binding arbitration process for when contracts are challenged or terminated and services are reconfigured

Reforming the reforms

In a range of key areas there is an urgent need to reform the current reforms. The RCN therefore recommends that:

- ◆ the government needs to work with the RCN and key stakeholders to develop and implement a sustainable, fully-costed and properly resourced transition plan for delivering care closer to home
- ◆ the government must use the forthcoming Comprehensive Spending Review to provide sustained investment in recruiting, retaining, educating, training and developing nursing staff
- ◆ there must be robust mechanisms put in place to ensure that patients, the public and the organisations that represent them are properly and fully consulted in respect of all health service reforms, reconfigurations and redesigns. These robust mechanisms could be backed up by sanctions such as penalties for those disregarding their consultation obligations
- ◆ the forthcoming NHS code on advertising and marketing must be backed up by credible and enforceable sanctions to prevent, and if necessary, punish rule breaches
- ◆ the financial and human resources should be put in place in order that the full, and as yet untapped, capacity of the NHS can be used for the benefit of patients and taxpayers
- ◆ the Chancellor must sustain a level of NHS funding increases greater than the expected growth in the economy over the period covered by the 2007 Comprehensive Review (i.e. for the years 2008-09, 2009-10 and 2010-11).

Conclusions

This RCN document is published at a time of great political activity. There have recently been elections in Northern Ireland and, in May 2007, there will elections for the Welsh Assembly and Scottish Parliament.

Moreover, with the impending retirement of the Prime Minister, Tony Blair MP, there is the real possibility of an earlier than expected UK General Election.

The RCN believes that the NHS should be the number one priority for every politician and every political party. So, to all those who aspire to govern, the RCN's message is this:

- ◆ it's time to tackle the deficits crisis
- ◆ it's time to value nurses and their colleagues in the NHS Team
- ◆ it's time to talk to, and work with, frontline staff
- ◆ it's time to reform the reforms
- ◆ it's time to safeguard patient care
- ◆ it's time to support and sustain our NHS – today and tomorrow.

Appendix

The RCN's trust by trust breakdown of NHS posts lost

Acute Trusts

Trust	Lost NHS posts (whole time equivalents)
Ashford and St Peter's Hospitals NHS Trust	100
Barking, Havering and Redbridge Hospitals NHS Trust	650
Barts and The London NHS Trust	330
Bedford Hospital NHS Trust	200
Bolton Hospitals NHS Trust	130
Brighton and Sussex University Hospitals NHS Trust	400
Chesterfield Royal Hospital NHS Foundation Trust	43
City Hospitals Sunderland NHS Foundation Trust	500
County Durham and Darlington NHS Foundation Trust	500
East and North Hertfordshire NHS Trust	500
East Kent Hospitals NHS Trust	500
East Lancashire Hospitals NHS Trust	300
East Sussex Hospitals NHS Trust	500
Epsom and St Helier University Hospitals NHS Trust	74
George Eliot Hospital NHS Trust	38
Gloucestershire Hospitals NHS Foundation Trust	500
Hammersmith Hospitals NHS Trust	300
Hereford Hospitals NHS Trust	60
Hinchingbrooke Health Care NHS Trust	100
Homerton University Hospital NHS Foundation Trust	99
Ipswich Hospital NHS Trust	370
James Paget University Hospitals NHS Foundation Trust	150
Kingston Hospital NHS Trust	95
Leeds Teaching Hospitals NHS Trust	435
Maidstone and Tunbridge Wells NHS Trust	300
Medway NHS Trust	160
Mid Essex Hospital Services NHS Trust	100
Mid Staffordshire General Hospitals NHS Trust	92
Mid Yorkshire Hospitals NHS Trust	1,100
Moorfields Eye Hospital NHS Foundation Trust	20
Newham University Hospital NHS Trust	100
Norfolk and Norwich University Hospital NHS Trust	145
North Cheshire Hospitals NHS Trust	104

Trust	Lost NHS posts (whole time equivalents)
North Tees and Hartlepool NHS Trust	74
North West London Hospitals NHS Trust	250
Northampton General Hospital NHS Trust	142
Northern Devon Healthcare NHS Trust	60
Nottingham University Hospitals NHS Trust	1,200
Oxford Radcliffe Hospitals NHS Trust	600
Pennine Acute Hospitals NHS Trust	325
Peterborough and Stamford Hospitals NHS Foundation Trust	185
Plymouth Hospitals NHS Trust	400
Poole Hospital NHS Trust	50
Portsmouth Hospitals NHS Trust	250
Queen Elizabeth Hospital NHS Trust	145
Queen Mary's Sidcup NHS Trust	400
Royal Berkshire Hospital NHS Foundation Trust	312
Royal Cornwall Hospitals NHS Trust	300
Royal Free Hampstead NHS Trust	480
Royal United Hospital Bath NHS Trust	300
Royal West Sussex NHS Trust	200
Sandwell and West Birmingham Hospitals NHS Trust	800
Shrewsbury and Telford Hospital NHS Trust	199
South Tees Hospitals NHS Trust	60
Southampton University Hospitals NHS Trust	564
St George's Healthcare NHS Trust	150
Stockport NHS Foundation Trust	50
Surrey and Sussex Healthcare NHS Trust	400
Swindon and Marlborough NHS Trust	200
The Mid Cheshire Hospitals NHS Trust	150
The Royal Wolverhampton Hospitals NHS Trust	300
The Whittington Hospital NHS Trust	90
United Lincolnshire Hospitals NHS Trust	317
University Hospital Of North Staffordshire NHS Trust	500
University Hospitals of Leicester NHS Trust	900
West Hertfordshire Hospitals NHS Trust	500
West Suffolk Hospitals NHS Trust	200
Weston Area Health NHS Trust	29
Whipps Cross University Hospital NHS Trust	90
Worcestershire Acute Hospitals NHS Trust	750
York Hospitals NHS Trust	200
Total	21,117

Mental Health/Learning Disabilities Trusts

Trust	Lost NHS posts (whole time equivalents)
Dorset Healthcare NHS Trust	100
Norfolk and Waveney Mental Health Partnership NHS Trust	40
North Staffordshire Combined Healthcare NHS Trust	200
Total	340

Primary Care Trusts

Trust	Lost NHS posts (whole time equivalents)
Bedfordshire PCT	50
City and Hackney Teaching PCT	40
Coventry Teaching PCT	90
Devon PCT	30
Gateshead PCT	174
Herefordshire PCT	50
Isle Of Wight NHS PCT	6
Kensington and Chelsea PCT	100
Kingston PCT	150
Leicester City PCT	30
Lewisham PCT	25
Northamptonshire PCT	48
Nottingham City PCT	9
Nottinghamshire County PCT	16
Sutton and Merton PCT	40
West Sussex PCT	18
Worcestershire PCT	30
Total	906

Grand Totals for all NHS bodies

Acute	21,117
Mental Health/Learning Disabilities	340
PCT	906
Total	22,363



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