

Conservative Party

The future of nursing: a consultation

Royal College of Nursing submission

1.0 Executive summary

- The RCN supports the decision to move nursing to an all graduate profession. The RCN believes graduate preparation is necessary for assisting staff to manage the demands and pressures of the role and to enable nursing staff to meet future patient needs. However, to ensure entry into the profession is widened and to attract those that would not normally consider going to university other means should be adopted, such as step on and off points and the ability to transfer between institutions.
- The RCN believes that quality is the central principle of nursing and research has demonstrated that nursing is essential to achieving quality outcomes and patient experience.¹ Further evidence has shown that to ensure quality it is vital that there are appropriate staffing levels and skill mix.²
- The UK has an ageing population. The increase in chronic and long-term conditions and the focus on a preventative approach to public health will change the demands for healthcare. Arguably care and support are going to play a greater role in the future and nursing is vital to meeting this need. However, investment in education, workforce planning and training and development needs to take place to support nurses in meeting these changing demands.
- There is a need to promote the nursing voice within organisations. The RCN would like to see greater investment in nursing leadership. To ensure a quality service all organisations that commission and provide nursing services should have the input of an executive nurse at board level. Nurse executives should have the opportunity to regularly update Trusts/Boards about the standard of nursing provided in their organisation, from the care provided by the most junior of healthcare assistants, to that provided by consultant, specialist and advanced nurses. While the majority of providers recognise the need for the input of an executive nurse at board level, the RCN is concerned that this recognition is not shared by commissioning bodies.
- The RCN remains strongly committed to the Agenda for Change (AfC) pay system and the retention of the independent Pay Review Body for the NHS. AfC is a flexible UK wide pay system which can deliver equal pay, local job design and team working. It is also flexible enough to deal with local labour

¹ Peter Griffiths with Simon Jones, Jill Maben and Trevor Murrells: *State of the art metrics for nursing: a rapid appraisal* (King's College London, 2008).

² Dr Foster Intelligence (April, 2009)

market issues through High Cost Area Allowances and Local and National Recruitment and Retention Premia. We remain concerned at reports from members that many organisations down band/grade nursing staff solely in an effort to reduce staffing costs. This issue is one about how local services are managed and financed rather than a problem with the AfC pay system.

- The RCN believes there needs to be a cultural shift towards openness and transparency in the management of every healthcare organisation. The RCN would like to see organisations give greater attention to the delivery of safe quality healthcare. This should include listening to and acting upon patient and staff feedback.
- The RCN has launched a dedicated phone line for those RCN members who wish to talk in confidence about concerns that patient safety is being put at risk in their workplace. The RCN will use this information to support members to take their concerns further. However, the RCN believes healthcare organisations need to place greater emphasis on introducing measures to reduce the risks of violence and protecting those staff who raise concerns in the workplace.
- Healthcare assistants have taken on expanded and advanced roles and are increasingly part of the nursing team. In recognition of this, and for patient and public protection issues, the RCN believes there is an overwhelming case for them to be regulated. The RCN does not believe the introduction of the Independent Safeguarding Authority will resolve the need for healthcare assistants to be regulated.
- To counter the predicted shortfalls in the number of nursing staff, the RCN believes more can be done to promote the profession to school leavers and mature potential students and to inform the public about the varied roles of nursing staff. To further reduce attrition rates amongst nursing students the RCN would recommend a number of measures, including: supporting students financially, ensuring childcare places and facilities are available to students who are parents and providing quality clinical placements.
- To ensure the development and advancement of the nursing workforce it is essential that there is a continued investment in nursing research and clear, well supported academic pathways for these nurses. The RCN believes continuing learning and development opportunities for all staff are essential to ensure safe and effective care, including protected training time as part of their continuing professional development and preceptorship for all newly registered staff.
- Nurse educators are essential to the development of the present and future workforce. To ensure sufficient nurse educators in pre-registration education they must be remunerated appropriately and given the necessary support to undertake doctoral programmes.
- Workforce planning must be an integral aspect of overall service planning and should be integrated with finance and commissioning services and training.

RCN priorities for workforce planning include ensuring clear and transparent decision making, incorporating workforce planning within NHS management development programmes and using the Electronic Staff Record more effectively to provide more information about the labour market.

- The RCN would like to see greater investment in developing role clarity for new and emerging nursing roles, particularly where nurses have developed these roles in response to changing demands for services.

2.0 Introduction

2.1 With a membership of almost 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

2.2 The RCN welcomes this consultation paper which aims to set out the Conservative Party's vision for the future development of nursing. The paper addresses some key themes for nursing and many of the issues raised are of mutual concern to the RCN.

2.3 In formulating our response the RCN asked for members' contributions via its website and a number of responses were received from nursing staff across the UK. The RCN also drew on the work that took place as part of our response to the Prime Minister's Commission on the future of Nursing and Midwifery.

2.4 The RCN has members across England, Northern Ireland, Scotland and Wales. As health is a devolved matter the issues and systems in place differ amongst the UK.

2.5 The Conservative Party has recently entered a partnership arrangement with the Ulster Unionist Party. The RCN welcomes this attempt to bring a new dimension to the politics of Northern Ireland.

3.0 How can nurses capitalise on the freedom which flows from removing central-process driven targets to deliver higher quality care?

3.1 While outcome measures are important the RCN would like to see greater emphasis given to the quality of care delivered. Outcome measures do not necessarily indicate quality, ie. a patient with bowel cancer may have had the tumour removed successfully but could have received poor care, been left ill informed, anxious and worried. Outcome measures must therefore include quality indicators and not just focus on medical measures. The RCN believes outcome measures should consider such things as the nurse-patient relationship, communications, coordination of care, healthcare associated infections, dignity, nutrition and nurse staffing levels. A study by Peter

Griffiths with Simon Jones, Jill Maben and Trevor Murrells demonstrated that nursing care contributed significantly to quality outcomes and patient experiences, as well as showing how quality indicators could hold all service providers accountable.³

- 3.2** The number and experience of nursing staff is critical to outcomes. An independent review commissioned by the RCN in 2006 put forward convincing evidence of a direct relationship between the registered nurse workforce and patient outcomes in acute hospital settings. The paper surveyed nearly four thousand nurses and looked at 118,752 patient episodes of care in 30 hospital Trusts in England. The research found that wards with lower nurse to patient ratios had a 26% higher patient mortality rate. The research also suggested that higher numbers of registered nurses and a higher proportion of registered nurses within the nursing workforce are associated with reductions in patient mortality, incidence of respiratory, wound and urinary tract infections, number of patient falls, incidence of pressure sores and medication errors.⁴ Moreover, research by Dr Foster's Intelligence demonstrated a direct link between nurse staffing levels and patient mortality.⁵
- 3.3** Whilst benchmarks such as Essence of Care in England, Fundamentals of Care in Wales and Clinical Quality Indicators in Scotland exist there is a need to help nurses to be clear about the standards expected of them and to help them within a systematic approach to evaluation and development of their practice to demonstrate their ongoing effectiveness. This requires a set of standards focused on everyday activity across the UK that all nurses are expected to meet in a form the public can recognise and value.
- 3.4** Further work is required on making such a set of consensual standards explicit. It is also crucial that we take forward the identification of criteria, indicators and measures linked with the electronic health record. Standardised language that enables the contribution and effectiveness of nursing to be judged will be fundamental to success. These measures need to focus on the basics as well as the promotion of health and well being. Further commissioned research and development is required into the processes that enable transformation of practice, innovation and investment in the evidence base on the impact of and nursing in all sectors.
- 3.5** The patient experience of care needs to be understood in order to support the evaluation of the care delivered. However there is also a need for more exploration of patient's expectations as distinct from assessing satisfaction with existing systems and processes.
- 3.6** The RCN believes that in order to ensure quality in the health service, patient-reported outcomes measurements (PROMs) - outcomes of direct importance and relevance to patients - need to be effectively captured. These measures may be useful in terms of reflecting the impact of nurses and nursing

³Ibid.

⁴Professor Anne Marie Rafferty of Kings College, University of London, Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records (International Journal of Nursing Studies, October 2006)

⁵ Dr Foster Intelligence (April, 2009)

especially around safe, effective and person centred approaches to care which meet patient's expectations and needs.

3.7 However, not all PROMs are reliable and able to generate valid data in terms of effective care delivery and there needs to be greater stability in the system to enable these types of approach to flourish.

3.8 The RCN would like to see greater attention given to outcome measures of chronic and long-term conditions. As chronic and long-term conditions are not curative, and thus are about successful management and stabilisation of the condition, outcome measures are not easily applicable.

4.0 **What other mechanisms to give nurses a strong voice and improve staff safety should be considered?**

4.1 The RCN believes that nurses must lead and deliver care as well as supervise others. The profile of the nursing workforce is changing with the increased use of healthcare assistants and assistant practitioners. The RCN believes that continuing learning and development opportunities for all staff are essential to ensure safe and effective care.

4.2 Furthermore, to increase nurses' influence and ensure staff safety the RCN is calling for action to:

- tackle physical violence and verbal abuse towards nurses and other healthcare workers by prosecuting their attackers and investing in measures to reduce the risks of violence to all, including lone health workers
- ensure that employers implement the Health and Safety Executive's Management Standards as a means of addressing the causes of workplace stress such as workload and demands on healthcare staff
- legislate for a preventative approach to the protection of nurses and other healthcare workers from potentially life threatening needle stick and sharps injuries including the provision of safer needle devices and systems
- protect the health and safety of nurses, patients and other healthcare workers by ending the practice of opting out from the 48-hour working week and ensuring compensatory rest for those who work on-call
- ensure that nurses who raise concerns in the workplace are protected when they speak out
- commit to workplace representation and partnership working (as per the formalised approach to partnership working in NHS Scotland) as an effective way of managing staff relations.

4.3 In addition, appropriate staffing numbers, skill mix, deployment of registered nurses, education and training, culture of the ward/clinical area and clinical leadership all impact on the safety of staff and the standard of care delivered. The RCN's report: *Breaking down barriers, driving up standards: the role of*

the ward sister and charge nurse, demonstrates that strong clinical leadership is essential to ensuring staff concerns reach board level.⁶

- 4.4** The RCN would like to see more decision making shared and conducted in public. Whilst commercial sensitivity is important, an overriding concern must be for public accountability for decisions made on behalf of taxpayers. As spending slows in the NHS, the profession may find its commitment to speaking up for quality care challenged. Some nurses have reported to the RCN that they feel they are being targeted first for redeployment, redundancy or disciplinary proceedings as a result of raising concerns. The RCN, in its oral evidence to the Health Select Committee, stated that nurses who reported unsafe incidents at Mid Staffordshire Hospital were informed that their concerns were ‘being placed in a waste paper basket’.
- 4.5** An RCN survey of 5,000 members in May of this year found that that the majority (78%) said they would be concerned about victimisation, personal reprisals or a negative effect on their career if they were to report concerns to their employers. More than a fifth of nurses (21%) revealed that they had been discouraged or told directly not to report concerns at their workplace and less than half (46%) felt confident that their employer would protect them if they spoke up. The vast majority (99%) of registered nurses understood their professional responsibility to report worries about patient safety but fears about personal reprisals meant that less than half (43%) would be confident to report concerns without thinking twice.
- 4.6** Of those who had reported concerns (63%), nearly half (49%) had filled in incident forms which are a formal mechanism for documenting situations that are a potential threat to patient safety. Despite using a variety of methods to report concerns, less than a third of nurses (29%) said that their employers had taken immediate action to resolve the situation. Worryingly, more than a third (35%) said that no action was ever taken.
- 4.7** As a result of this survey and concerns raised by members the RCN has launched a dedicated phone line that will allow RCN members to talk in confidence about serious and immediate worries that patient safety is being put at risk in their workplace. The RCN will then use this information to support the nurse to raise concerns and, if needed, will step in swiftly to investigate concerns directly with employers.
- 4.8** The RCN is calling for significant changes to the way that employers respond to staff concerns to make sure that all healthcare workers are properly protected when speaking out about risks to patient safety. In particular, the RCN believes that all healthcare organisations should be required to hold a register of staff concerns that must be reported to their Board regularly and be made available to the public.
- 4.9** The RCN is also calling on all healthcare employers to make a public pledge that gives a categorical commitment that staff will be protected from

⁶Royal College of Nursing, *Breaking down barriers, driving up standards: the role of the ward sister and charge nurse* (2009)

victimisation and reprisals if they speak out. Employers should ensure all employees are fully aware of whistleblowing policies and procedures. The RCN's survey showed that nearly half of all nursing staff (45%) didn't know if their employer had such a policy.

5.0 How can we help nurses have more influence and control over the patient environment?

5.1 The RCN has continued to highlight the crucial role of a skilled nursing workforce that provides both leadership and supervision in nursing care delivery. Through nursing staff taking a greater responsibility in leadership positions they can have greater influence and control over the patient environment. Nurse-led services can provide expert services that meet health care needs and the RCN would like to see greater investment targeted at enabling nurses to take the lead for innovative methods and new services.⁷ However, in order for nursing leadership to be effective there is a need for continuing and increased investment which recognises the importance of building the capability of nurses to improve patient care and champion nursing and patient quality at board level.

5.2 Nurse leaders and managers are responsible for the highest number of staff within the NHS. How they fulfil their role as leader/manager directly impacts on patient care, patient safety and staff morale.⁸ It is vital that the voice of nursing is adequately represented in the governance of the NHS at all levels. The culture of the organisation is central to the provision of ongoing, consistently high-quality care, which should always be at the top of the executive and non-executive boards' agendas. Board members should hear through their nurse executive about the standard of nursing provided in their organisation, from the care provided by the most junior of healthcare assistants, to that provided by consultant, specialist and advanced nurses.

5.3 To ensure a quality service all organisations that commission and provide nursing services should have the input of an executive nurse at board level. The RCN has published a policy position on the need for an executive director of nursing to be on the Board of each Primary Care Trust in England, regardless of whether that PCT is a provider or a commissioning body. Nurses are the largest professional group involved in care delivery and are in the unique position of caring for patients throughout whole pathways of care. They are also well versed at putting patients at the centre of care and acting as their advocates.

5.4 There is evidence that nurses currently hold negative views about aspects of organisational culture, such as the prevalence of 'blame culture'. These perceptions constrain many nurses from effectively contributing to reporting issues and concerns. This situation serves to dilute the nursing voice across organisations specifically, and reduce the potency of reporting systems nationally and the strategies used to address issues and concerns. Linked with perceptions of lack of management concern around issues such as skill mix it

⁷ Richard Hatchett, *Nurse-led clinics: practice issues*, Routledge (2003)

⁸ Nolan, A (2006) 'Leadership in Tune with the Team', *HSJ*, 20th June 2006.

also impacts on staff motivation and commitment. There is a need to promote the nursing voice within organisations, not only to encourage reporting around safety but also to contribute to improved workplace cultures and to encourage sharing of good practice and innovative approaches to care.

5.5 Attention needs to be given to the delivery of quality and safety in care rather than focus solely on finance and targets as the drivers of patterns of care – this focus needs to be realised rather than just espoused. Open, honest and transparent management that engages the workforce, draws on their expertise and shows a willingness to learn from past mistakes, illustrated by the concept of organisational readiness, are essential starting points.⁹

5.6 Enabling strategies that organisations can use include:

- ensuring senior managers are visible and understand and experience the day to day provision of healthcare
- combining targets with a culture that enables innovation and creativity
- listening to and acting on patient and staff feedback
- acknowledging and providing incentives for creativity, innovation and improvements in patient care
- ensuring there is an infrastructure of expertise that enables better spread and mainstreaming of both quality and innovative practice
- ensuring technology is user friendly and supports nurses in providing quality care
- working with professional organisations and patient/public representatives to focus attention on the relevant issues and potential solutions.

5.7 The term “clinical leadership” needs to embrace nursing in the same way it embraces medicine. The term is frequently misused and is, in reality, a pseudonym for “medical leadership”. Whenever there is a requirement to consult with clinical leaders, or to have clinical leadership representation, there is either an absence of nurses in the room, they are in a minority group, or they are present as a token gesture. Examples include membership of Primary Care Trusts, NHS Trust Boards and clinical leadership positions in acute specialities. Sadly, and to the detriment of patient care, the contribution of nurse leadership and nursing is often undervalued by NHS managers.

5.8 Greater emphasis needs to be placed on the further development of executive nurses, matrons, ward sisters/ charge nurses, specialist and advanced practitioners and nurse consultants as clinical leaders. The ability, role and function of the nurse executive is critical to the success of a healthcare organisation and needs careful preparation, investment and support if it is to fulfil its potential. Nurse executives have a complex, expanding and demanding role with a portfolio which requires expertise in strategic planning, business management and clinical care. Nurse executives are well placed to identify clinical risks and report on the management of risks within their organisation. However to be able to do so, it is essential they have access to

⁹ Ibid.

comprehensive audit systems and data analysis, supported by robust reporting processes relating to the provision of high-quality care.

- 5.9** The ward sister / charge nurse / team leader provides the link between management and the front line staff who personally interact with the public and patients. They are the interface between management and care delivery, and can only be effective if they have the support, the time, authority and respect necessary to competently and visibly lead their teams on the delivery of high-quality care.¹⁰ However, many ward sisters feel inadequately prepared for their role and find that others regard them more as managers than leaders of the care environment and leaders of a team of staff. This group of senior nurses need access to tailored leadership and management development programmes, peer review, mentorship and shadowing opportunities.
- 5.10** In order for nurses to be successful in these leadership roles they will need to develop a range of influencing skills. These skills should include an ability to politically influence at a strategic organisational level to ensure that the clinical knowledge of nurses is translated into meaningful messages. Utilising their clinical knowledge and expertise and translating this into meaningful information and data, together with an understanding of financial budgeting, policy drivers and constraints are vital.
- 5.11** Nursing roles are constantly evolving, in primary and acute care. Recent developments in the community and primary care sector and the Transforming Community Services initiative in England in particular, have highlighted a need for nurses to increase their skills in and knowledge of commissioning and to develop financial acumen. The RCN believes it is as essential for nurses to take a leading role in commissioning, including holding directorships on PCT boards, if it is to lead in the provision of care. However, not only is there a skills gap, there is an issue about the popular perception that leadership roles in commissioning and procurement require a background in finance or accountancy. Central to good commissioning is an understanding of clinical services.
- 5.12** To assist nursing staff, management training for nurses could include a component on how national policy is made and shaped. The RCN has a successful 'Political Leadership Programme' that assists nurses in understanding political reality and the influence on policy making. Local councillors, MPs, MSPs, AMs and MLAs should be encouraged to undertake shadowing opportunities with nurses from their constituency.
- 5.13** Section 1.2.3 of the consultation suggests a pilot programme that would allow a junior nurse representative to sit on the Board of a Trust on a rotational basis. The RCN supports moves to allow nursing staff gain a greater clinical understanding and contribution to high level decision making. However, the RCN would like to see emphasis given to supporting and developing nursing leadership and introducing programmes to encourage the next generation of leaders in the nursing workforce. Investment needs to be made at every level

¹⁰ Ibid.

to create opportunities for all staff to be involved in the decision making process.

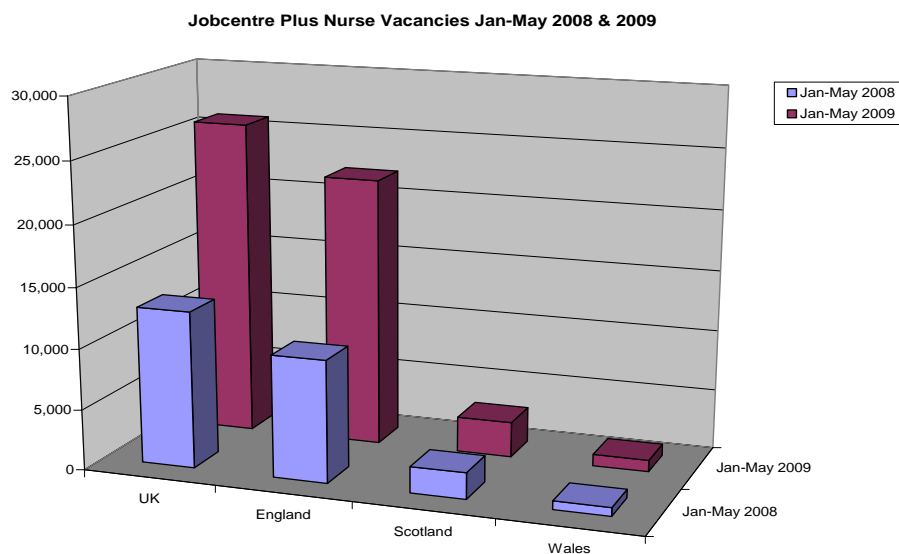
6.0 How can the nursing profession be made more attractive to school leavers, graduates and to people seeking a second career, so that retiring older nurses are replaced?

6.1 It is the view of the RCN that the nursing labour market is tightening and on the brink of a shortage that could severely constrain the potential for nurses and midwives to help improve the quality of services for those who are sick, to promote health and well-being and particularly, to develop primary and community care services.

6.2 While there is no ‘official’ shortage according to the Department of Health (DH) at the moment this is partly due to the way vacancies are counted. A vacancy is defined by the DH as ‘an empty position which has lasted for three months or more and which employers are actively trying to fill’. The key word here is ‘actively’ – i.e. if a trust is not ‘actively’ recruiting there are technically no vacancies. This leads to great distortions during times of delaying or freezing recruitment.

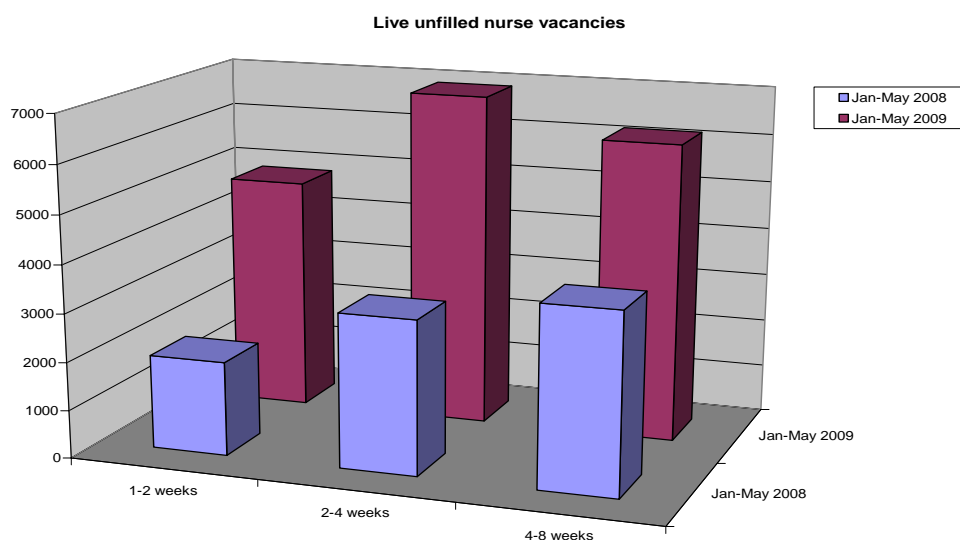
6.3 Jobcentre Plus data shows that nursing vacancies have greatly increased since last year. The data revealed a rise in advertisements for nurses over the past four years, but the biggest jump, from 2,198 to 6,429 occurred last year. The increase in London alone over the past year was from 296 to 1,147.

6.4 The following graph¹¹ shows the difference in notified nurse vacancies, comparing the first five months of 2008 with the same period this year. There have been significant rises in advertised vacancies in each of the UK countries with the overall figure rising from 12,913 in 2008 to 25,962 so far in 2009.



¹¹ <https://www.nomisweb.co.uk/>

6.5 The same trends are evident when looking at the unfilled vacancy data from Jobcentre Plus, with the total number of unfilled nursing posts at 1-2 weeks increasing from 1,952 in the first five months of 2008 to 4,854 for the same period in 2009. The number is considerably higher at 2-4 weeks, from 3,190 in 2008 to 6,914 in 2009 and remains high at 4-8 weeks, from 3,732 in 2008 to 6,173 this year.



6.6 These figures cause concern to the RCN. The rise could be due in part to more staff leaving the profession as they reach retirement age, a trend that is set to increase over the next ten to twenty years.

6.7 Moreover, there is a lag of several years between decisions made on funding levels for pre-registration nurse education and when these “new” nurses enter the register. The effects of reductions in commissioning in 2005/06 in England will soon start to become apparent with a corresponding reduction in the number of trained nurses coming into the system. Recent decisions by the Migration Advisory Committee that close the door to internationally educated nurses at the same time will only exacerbate this situation. The RCN has repeatedly called for better and more joined up workforce planning including input from the devolved administrations and the independent sector.

6.8 In order to counter shortages in the nursing profession there is much more that can be done to attract suitable candidates to the profession. A media campaign could highlight not only the excellent care provided by hospital nurses, but also the work that is currently carried out by nurses working in the community, across all fields of practice. Nursing can offer an exciting and multi-faceted career for life, it is global and offers a range of opportunities in ground-breaking technology and research in a variety of settings. The RCN believes more can be done to promote the image of nurses and to portray their role in a positive manner.

6.9 The profession needs to be seen as a vibrant, though challenging career by intelligent school leavers and mature potential students. The role of nursing staff has changed dramatically in recent years and the public perception of

nurses and what they believe to be the role of the nurse may not be completely accurate. Today's nursing profession undertakes a variety of roles from school nurses to defence nurses and many are now qualified to prescribe and undertake a range of complex procedures such as colposcopies and hysteroscopies or to provide therapeutic support and professional counselling for patients who need these specialist services. It is important that their role is described in an honest and factual way so that the public have a better understanding and clearer expectations of nursing staff.

6.10 Despite the many reports and press coverage on the provision of poor nursing, the profession continues to be largely respected and trusted by the public. However, it is important to constantly reflect on how the public sees nursing, what it expects from it and how it needs to adapt to meet changing expectations and needs. The public perception of nursing is vital to encouraging people into the profession and thus the profession needs to be able to build on good practice and tackle any weaknesses or deficits which compromise the way the public values nursing.

6.11 Moreover, the public perception of nursing is influenced by the government. It is therefore essential that the government recognises the potential of the nursing workforce and the valuable contribution they provide to the nation's health.

7.0 Would a move to a degree level profession work better if access to degrees was broad and the degree structure itself more flexible?

7.1 The decision has been made for graduate entry to the profession to be implemented across the UK by 2015 (however, please note that nursing is already an all-graduate profession in Wales). The RCN strongly supports this decision and believes graduate preparation is necessary to meet future patient needs. Moving to an all-graduate profession will mean that there is much work to be done to encourage both school leavers and mature students to continue to enter preparation programmes for nursing. This will involve co-operation with the careers services and those who prepare applicants through courses in further education colleges and Trusts/Boards.

7.2 Pre-registration programmes need to relate closely to the demands of a modern health service which meets public expectations and reflects the ageing demographic of the population. The NMC should take note of health policy challenges in all four countries within the UK and make the changes required to nursing curricula which ensure newly qualified nurses are equipped to work in a health care environment such as that described in Transforming Community Services in England.

7.3 The RCN believes that it is correct to offer nurse education as a degree level profession and is already in discussion with the NMC, Council of Deans of Health and other stakeholders about how we ensure that the entry gate is as wide as possible. To attract a more diverse workforce the entrance procedures should be simplified. Options like those adopted by UCAS, such as the pathways for those already at degree level and the ability to transfer between institutions, would simplify the entry procedure for many candidates.

- 7.4** The average age of student nurses is 29 years old and thus the circumstances of a nursing student differ to your typical university student. The RCN believes recognition needs to be made of this during the selection of candidates. The RCN would like to see a more flexible degree structure to take into account students with families and carer responsibilities. Further development of the present modular programmes to offer more flexibility would be welcomed. In particular, the RCN believes it would be helpful to look at the skill elevators approach with stepping off and on points to aid career progression and development i.e. a careers framework.
- 7.5** The RCN would welcome any measures to protect nurse training budgets as set out in the consultation document.
- 8.0** **How can we make the pre-qualification training of nurses more secure and reduce the high attrition rate?**
- 8.1** Last year the RCN carried out a study into the challenges facing today's nursing students in the UK. The study of over 4,500 nursing students across the UK found that 44% of respondents had considered leaving their nursing course. By far the most common reason for considering leaving was for financial reasons (62%) with students reporting financial debts from less than £1,500 to more than £10,000.¹²
- 8.2** To help more students to stay on their course and to enhance their learning experience the RCN recommends the following:
- recognise the changing demographics and ensure that appropriate flexible support is available to suit the diverse student population
 - examine the reasons why students consider leaving and ensure higher education institutions can implement and sustain policies to identify at risk students, including looking at ways to maximise tutors awareness of those considering leaving
 - ensure the range of possible interventions from higher education institutions to support students is funded to include services they value including additional tuition, online support, help lines, buddy services and pastoral care
 - focus on ensuring quality clinical placements including concentrating on mentorship, communication and location of placements to reduce, where possible, unnecessary travel
 - provide resourced services to ensure nursing students can access counselling should they need this service
 - ensure childcare places/facilities and options are available to parents
 - address students' financial debt and levels of paid work by providing adequate financial support
 - assure students that on completion of their training they would have access to preceptorship support during their first post.

¹² Royal College of Nursing, *Nursing our Future* (London, November 2008)

- 8.3** If the profession is to attract high calibre mature students we must tackle problems attached to childcare, bursaries and the ‘passport’ which would enable a student to transfer from one higher education institution to another more easily when family commitments make this necessary.
- 8.4** If future nursing is to deliver what is demanded of it, a number of educational benefits awarded to the medical profession should be more equitably shared. We need to explore how high-quality preceptorship, continuing professional development, clinical placements and mentorship can be made accessible to all students and qualified nurses, not just the few. While the cost of such developments is significant, the investment will result in a far higher and more consistent provision of excellent nursing care. Ensuring all newly-qualified nurses receive a properly supported period of induction and preceptorship when they begin their employment will assist the transition from student nurse to practitioner and aid in lowering the attrition rate.
- 8.5** Expert mentorship to nursing students in clinical practice is essential to ensuring nursing students feel supported and assists in lowering attrition rates. The role of the mentor needs to be seen as a more attractive option to nurses and should thus be remunerated accordingly. Moreover, there should be adequate training and time given to those who wish to undertake the role.
- 8.6** The RCN also believes that providing nursing students a clinical placement should attract incentives in the same way that providing medical students a placement draws a payment. This would help increase the professional interaction between students and nurses and we believe would lower attrition rates.
- 9.0** **How can we improve the suitability of candidates and the content and structure of pre-registration education so that it meets the needs of nurses and the NHS?**
- 9.1** To ensure the development and advancement of the nursing workforce it is essential that there is a continued investment in nursing research and clear academic pathways for nurses undertaking these roles. To ensure quality care is underpinned by detailed and thorough evidence it is essential that the clinical career framework is considered alongside the clinical academic career pathway.
- 9.2** Nurse educators are highly experienced and qualified professionals who have worked as practising nurses for several years before moving into lecturing. While practising and often at their own expense and time, nurse educators complete advanced specialist courses to at least masters level (with an increasing number at doctorate level). In addition to this, on entering university they will undertake a teaching course and continue to advance their professional knowledge base. Nurse educators are essential to the development of the present and future workforce and to the maintenance of high quality care through their delivery of pre-registration and advanced programmes to the nursing workforce.

- 9.3** Most nurse educators work in universities where recruitment would be easier if, like medical colleagues, there was free movement of pension between the NHS and higher education institutions. It would also be easier to recruit if those who continued to maintain practice competency through a patient care commitment were to receive the clinical lead on salary paid to similar medical lecturers. Support should be offered to enable these lecturers to undertake doctoral programmes, such as professional doctorates, which would allow them to lecture in theory and practice at the highest possible level.
- 9.4** A smaller number of nurse educators work in further education colleges as practice educators and in other teaching roles in Trusts/Boards. It is important to the provision of high quality nursing that these staff receive salaries which reflect their value and have access to personal and professional development.
- 9.5** To be successful the process of commissioning in England requires detailed indicators both at local and national levels. Such information is often in the hands of clinicians however it is rarely evaluated, consistently collected or shared. Nurses are able to work together across professions for commissioning of services to ensure services are patient focused rather than organisation or profession focused.¹³ Current pre-registration education does not prepare them well for that environment and post-registration opportunities are severely limited. More could be done to clearly signal the intention to have clinical leadership in commissioning at the practice, locality and regional level.
- 9.6** The RCN recognises the valuable guidance produced by the NMC for nursing students and their mentors. This guidance provides clear and concise information for students about the standard of personal and professional conduct expected of them and can be used by mentors and academic staff to support their students' learning.
- 9.7** In response to the consultation document's comments in section 2.2.5 the RCN would like to clarify that the NMC expects nurse education training providers to conduct face-to-face interviews with selected applicants. This interview should include someone from the local commissioning Trust. The RCN would like to see a variety of assessment methods undertaken with candidates, including interviews taking place in a clinical environment and incorporating a practice-based element.
- 9.8** Furthermore, the RCN believes the relationships between higher education institutions and practice providers in the development of programmes needs to be strengthened to ensure appropriate content to an agreed academic level.
- 10.0** **How can we improve workforce planning so it better reflects local service requirements? Is there a way nurses could engage with this process?**
- 10.1** Health and social care across the UK is changing rapidly and with it are changing demands on the workforce. The Health Select Committee 2007

¹³ K Wortham 'Clinical leadership for NHS commissioning: Exploring how allied health and other health professionals lead change through and beyond commissioning for a patient led NHS' NHS Alliance (2007)

report was highly critical of the workforce planning system in England. Jim Buchan's report: *Nurse workforce planning in the UK*, agrees that the England workforce planning systems have been challenged by under-capacity and major change and suggests that there are some challenges and gaps across all four countries.

10.2 Effective workforce planning should provide a balance between demand and supply for staff. The nursing labour market in the UK, England especially, needs to move away from a boom and bust cycle. Workforce planning is key to anticipating the impact of demographic, technological and policy trends on future service requirements and also as a possible way to improve efficiency in the service.

10.3 The RCN priorities are intended to focus on the cross national (UK)/national/local planning systems – identifying key principles, which should be relevant to workforce planning at all levels. In its evidence to the Health Select Committee inquiry on Workforce Planning (2006-7) the RCN argued for robust workforce planning at country, regional and employer levels. We also argued for a comprehensive coordination of workforce planning across the UK health sector.

10.4 The RCN believes workforce planning needs to:

- include key stakeholders: service planners, workforce planners, service commissioners, education commissioners and providers, service providers both public and independent sector; and trade unions
- include key functions: finance, human resources, clinical directorates
- ensure all stakeholders are committed to and involved in the planning process with clear lines of responsibility, transparent decision making and well defined accountability
- support the utilisation of nationally agreed nursing workforce planning tools including the Keith Hurst tool and Professional Judgement tool (used in NHS Scotland)
- have an agreed national workforce plan which aggregates local/regional plans
- have a co-ordinated national and cross national approach to workforce analysis, which includes consultation with key stakeholders
- have an agreed framework for collating staff information with a system for sharing the data across sectors and across countries
- take account of the whole healthcare workforce rather than treating each profession as separate silos and excluding the independent sector
- support best practice in employment standards and in employment relations – supporting both recruitment and retention of staff during change.

10.5 The RCN believes workforce planners need to have a:

- structured information base on current staffing; staff budgets and relevant activity whether planning for a ward, organisation, region or country

- system for assessing workforce dynamics and “flows” between sectors and organisations within the system being planned for – assessing sources of supply and turnover
 - set of planning parameters linking workforce and activity data
 - framework for using “what if” analysis to model different scenarios for demand for services and the related staffing profile
 - framework for monitoring staffing changes in comparison to the plan – develop a cycle of review and update.
- 10.6** NHS planning is generally contentious as it exists within a highly political environment driven by demographic changes, financial constraints, and changes in the regulatory and legislative framework. Workforce planning not only needs to take account of these issues, but must also incorporate policy driver changes, such as moving care closer to the patient, changes in professional education, introductions of new roles and new ways of working, such as the Working Time Regulations.
- 10.7** Critical to having effective workforce planning is to ensure its integration with finance and service planning and with commissioning services and commissioning training. Workforce planning needs to be an integral aspect of overall service planning and should be influencing funding allocation, service reconfiguration and staffing decisions.
- 10.8** Nonetheless, workforce planning is not an exact science. It should not be expected to produce precise forecasts and results. Its purpose is to assist an organisation or systems planners to make better use of their internal labour market and to map the position of the organisation in the wider labour market. Used effectively it can enable organisations to respond flexibly to changes in the external labour market.
- 10.9** The central contribution of nurses delivering healthcare and the size of the nursing workforce, with its recurring paybill, training and education costs, mean that nursing is a major focus of planning in a highly labour intensive organisation. As such, planning to ensure effective use and deployment of nursing staff has a financial, operational and a political imperative.
- 10.10** The constant tension between measures of demand and cost will be particularly challenging in periods where key drivers are focusing on productivity gains and cost savings. One of workforce planning’s roles is to assist in understanding this tension – helping cost staffing and then hopefully influencing the levels of funding available, and decisions on affordability and resource allocation.
- 10.11** The RCN is not seeking to recommend any particular model of workforce planning, instead we have an agreed set of principles against which any particular model or system should be assessed.
- 10.12** RCN priorities for action on workforce planning include:

1. workforce planning having the same priority within the health services as financial and service planning. There should be identified workforce planning leads at all levels of the planning process. It should be clear to all stakeholders where the leadership for workforce planning lies – nationally, locally, and organisationally
2. clear and transparent decision making around workforce planning with accountabilities built into the planning process at cross national (UK)/ national and local levels
3. workforce planning capacity should be reviewed at all levels and capacity improved where required
4. improve the integration of workforce, financial and service planning – ensuring involvement of stakeholders and key functions. All business plans should make reference to workforce implications – where services are being redesigned, plans should have supporting workforce plans
5. workforce planning as an integral agenda item for Social Partnership Forums across the UK (a group consisting of NHS employers, trade unions and Government/Assembly officials to discuss, debate and involve partners in the development and implementation of the workforce implications of policy). All countries and regions should have a forum for joint discussions on workforce planning
6. workforce planning to be incorporated within NHS management development programmes. Managers at all levels should understand the workforce planning process and how it links with business and service plans
7. commissioners of services to include workforce information as part of the contract with provider organisations. All providers (public and independent sector) to provide workforce information to a standard template
8. more effective use of the Electronic Staff Record. The RCN is calling for more fields in the Electronic Staff Record to be mandatory and will lobby for Foundation Trusts to be required to supply similar data so that there can be more comprehensive analysis of the labour market
9. more effective use of NMC data – expand current data fields to include current employment status and to make a complete data routine a requirement of registration. In addition, the NMC database should be used to conduct a UK wide periodic review, funded by the four UK Health Departments and including all associated stakeholders.

11.0 How can CPD funding be secured to meet the personal ambitions of nurses and the long-term interests of the NHS?

11.1 Over recent years we have seen varied and in some cases poor investment in a wide range of educational opportunities. The preliminary findings from the RCN's 2009 Employment Survey showed that:

- in 2009 the amount of CPD undertaken remains lower than in preceding years, and is more or less the same as reported in 2007
- staff nurses in the NHS have undertaken less CPD (5.3 days) than other groups of NHS nurses

- just over six in ten nurses (61%) across all sectors have had an appraisal/development review with their manager in the 12 months prior to the survey. This figure is slightly higher than that reported in 2007 (58%)
- in general, mandatory training has increased marginally across the board since 2007. However, there is much more infection control training reported by nurses in NHS hospitals than was the case in 2007 (80% in 2009 compared to 63% in 2007) and more nurses working in independent care homes have also received infection control training (81% compared to 67% in 2007)
- views of access to training opportunities are slightly more positive in 2009 than was the case in 2007, but remain lower than was recorded in 2005.

11.2 By comparison, the NHS staff attitude survey for England 2008 records 40% of staff reporting they have good development opportunities, 64% had undertaken an appraisal in 2008 and 55% had a personal development plan. Implementation of the Knowledge and Skills Framework (KSF) has been variable and there are still groups of nursing staff, particularly in Foundation Trusts, who do not have a KSF outline for their role.¹⁴

11.3 Feedback from RCN members suggests that the reason for the low uptake of KSF is largely due to lack of organisational support for it at Trust level, rather than the complexity of KSF itself. The implementation of KSF has allowed nurses and NHS staff to demonstrate their development in their roles, access continued professional development opportunities and provide better care for patients. The RCN has published competences for nursing based on the KSF dimensions.¹⁵

11.4 If threatened cuts in public service finances become a reality for the NHS, the RCN fears that, as in the past, learning and development will be an easy target for cuts. This would not only be short sighted but also potentially dangerous. The RCN believes that continuing learning and development opportunities for all staff are essential to ensure safe and effective care, that every nurse and healthcare assistant should have protected training time as part of their continuing professional development and all newly registered staff should be provided with preceptorship.

11.5 The RCN has recognised both opportunities as well as obstacles to improvement of services as the NHS ‘market’ becomes available to non-traditional healthcare providers in a contestable field. Unless these new organisations are charged with ensuring the on-going learning, training and development of their staff, we could see further erosion of the skilled workforce. The RCN believes all new healthcare provider organisations should have a well-developed CPD plan for nurses as part of their business submission.

11.6 Post-registration advanced and specialist nursing programmes will be at master’s level and beyond, and need to be equally accessible to nurses

¹⁴ <http://www.cqc.org.uk/usingcareservices/healthcare/nhsstaffsurveys/2008nhsstaffsurvey.cfm>

¹⁵ Royal College of Nursing, *Integrated core competence and career framework for registered nurses*, (London, 2009)

working in all areas of healthcare. The RCN believes tax relief should be available to nurses who fund their own professional development programmes.

11.7 Models of care will be different in the future with greater emphasis focused on moving care from the acute sector to the community. Providing CPD to prepare nurses for these different roles and settings is essential to aiding change and meeting new health needs. The RCN supports any measures to protect CPD funding, however, it is essential that training funds are targeted at meeting these future needs.

12.0 **How can we ensure that CPD pathways are of a high standard and meet the needs of patients?**

12.1 Future nursing must focus on health inequalities, health improvement, self care, better health information for the public and the provision of excellent end of life care, all of which can take place in the community rather than the hospital. The underpinning principle being that nurses must have the right skills and knowledge, wherever they happen to be working.

12.2 The training and education of nurses has to change, so that it prepares them, upon registration, to function equally competently in the community and the hospital and to work with an increasingly ageing patient group.

12.3 The RCN believes quality, safety and innovation should be at the backbone of the career framework. Specifically we believe the following needs to take place:

- implementation of a curriculum at pre-registration and then post-registration that focuses on the essential standards expected of all nurses and then the development of expertise in person-centred, safe and effective practice
- implementation of curriculum post-registration that integrates movement towards advanced practice and consultant nurse practice that focuses on developing expertise in person-centred systems and whole systems approaches as well as the facilitation of this in others
- implementation of work-based learning, linked with clinical supervision as a key approach for enabling nurses to grow their expertise, provide quality, safe and effective care and thus the achievement of both professional and academic accreditation
- consideration of approaches to the quality assurance/revalidation of nursing practice.

12.4 A greater focus on work-based learning will enable practitioners to integrate life-long learning and bring benefits to both the individual and the organisation through using everyday work as the main resource for learning. 'Work based learning has potential to transform health care services to improve patients' and users' experiences, support the implementation of

evidence, provide value for money, improve productivity and achieve continued modernisation’¹⁶.

13.0 How can we ensure that the pay and banding system corresponds accurately to roles?

13.1 The RCN remains committed to the present independent Pay Review Body (PRB) process for the determination of annual pay increases. The PRB remit ensures that there is due recognition not only of the economic circumstances affecting the workforce and service but also the wider economy. We also believe that through High Cost Area Allowances and Local and National Recruitment and Retention Premia the Agenda for Change (AfC) pay structure enables pay to reflect local labour market and geographic issues whilst at the same time ensuring that nurses pay is essentially UK wide. The freedoms built into AfC for Foundation Trusts and others with earned autonomy allows the retention of a UK wide pay system along with such freedoms necessary for employers to, in partnership with NHS unions and professional organisations, develop parts of the pay system. The ‘benefits realisation’ element of AfC enables AfC to be used and developed to facilitate new ways of working whilst at the same time improving patient care and delivering efficiencies in the service. The RCN believes the pay system is transparent. Based on job evaluation, the system is one of the most transparent and open pay systems in Europe.

13.2 AfC is a pay and terms and conditions package for all NHS staff (excluding doctors and dentists). The implementation of AfC saw a reduction in the number of ‘roles’ in the NHS from 400,000 to 35,000.¹⁷ All NHS roles are underpinned by an NHS Job Evaluation Profile and matched against a single job evaluation system ensuring that the principle of equal pay for work of equal value is enshrined in the system. The nine band pay structure allows for clearly defined ‘roles’ with bands 5-9 covering the newly registered nurse to the nurse consultant.

13.3 For our members it is not always the banding system itself that causes a problem or difficulty – it is the management of the system by employers. An important issue which our members have raised with us is regarding ‘down-banding’ or what many employers would describe as ‘skill mix review’. As nursing contributes to a high amount of NHS spending (£28.2 billion in England in 2007/08) it is often the area that employers look to first for savings. In an effort to reduce costs employers often decide to review the number and type of roles required for a service or department. In general the outcome is that when they say ‘skill mix’ they mean ‘grade mix’, that is, they do not look at the skill sets required for the work but only at what someone is paid – the key driver is to reduce costs by reducing the number of higher paid posts.

¹⁶ Manley K et al (2009) Work based learning in the context of contemporary health care education and practice: A concept analysis. *Pract. Dev. Health Care* 8(2) 87-127

¹⁷ National Audit Office (2009), p13, para 1.20

- 13.4** Anecdotally our members tell us that these exercises often result in reductions of higher paid roles (for example Band 7 Advanced Nurse roles) with these nurses being placed into lower Band 6 roles and subject to pay protection. In these exercises often the level or complexity of work required does not alter merely the same service is delivered more cheaply and by the same people. Unfortunately, this causes considerable dissatisfaction as well as anger directed unjustly at the pay system rather than the employer. The irony of the situation is that despite the employer coming to a view that they do not need this higher level post they still expect the ‘down banded’ nurse to function at their previous high level. Such exercises took place after the 1988 implementation of Clinical Grading and are taking place now after the implementation of AfC.
- 13.5** Nurses are sufficiently conscious of the need for the NHS to regularly assess itself and adapt to changing patient and service needs. They also recognise that this might lead to alterations in service design and the manpower required. However, any such exercise has to be undertaken openly and based on clinical needs rather than as solely a cost reduction exercise. In our 2007 Employment Survey 44% of respondents stated that they did not think that they were on the appropriate pay band for the role they undertook. This figure has changed little since 2005.¹⁸ It is this issue which causes concern to nursing staff which is not in itself a problem of the AfC system but rather a problem with how services are managed at a local level.
- 13.6** In 2010/11 some welcome structural changes will take place to AfC pay band 5. This is the pay band that all new registered nurses enter. However, with the implementation of AfC a significant number of previous E grade nurses (senior staff nurses) also were assimilated in to this pay band. Our research indicates that 85% of E grades went to AfC pay band 5 – the same pay band as newly registered nurses.¹⁹ Those former E grade nurses have expressed concern that the development they undertook to get an E grade post has not been recognised in the new system. We would be interested in exploring further how an easier transition can be made between band 5 and band 6 that did not rely on having to wait for new posts to be created at band 6.
- 13.7** In response to the consultation document’s comments in section 3.2.3 the RCN would like to clarify that the KSF and its electronic tool, the e-ksf, is compatible with the Electronic Staff Record as they were built to be so. However, they do perform different functions. ESR is a HR tool for recording pay and banding of staff in the NHS, it also has the capability to enable ‘self-servicing’ of sickness absence and annual leave for staff as well as prove an audit tool for training. The e-ksf, on the other hand, was developed for recording appraisals and personal development electronically. The RCN has been involved in the design and implementation of the tool and its use.
- 14.0** **Should there be mandatory professional and academic benchmarks for different roles, and is there a need to streamline role definitions?**

¹⁸ RCN, *Holding On Nurses’ Employment and Morale* (2007)

¹⁹ Ibid.

- 14.1** The RCN would like to see greater investment in developing role clarity for new and emerging nursing roles, particularly where nurses have developed these roles in response to changing demands for services. Advanced nursing roles have enabled skilled nurses to expand their traditional roles, take on the prescribing of medication, leadership of services, innovative implementation of new ways of working, encourage self care and work with the expert patient programme. Nurses are keen to take on these new challenges but will need the support of their organisations and investment in their skill development to ensure that the NHS is fit for the future.
- 14.2** Well-trained and supported healthcare assistants and, increasingly, assistant practitioners are core to the delivery of safe and effective care in all healthcare settings. However, nursing teams must be developed which contain an appropriate blend of skill and grade mixes, which ensures they are capable of providing high-quality care to their patients. Skill-mix design should focus on patient need, not financial restraints. An over-diluted and inappropriate skill mix may save money in the short term, but will bring added and preventable costs in the longer term to the organisation. While healthcare assistants and assistant practitioners are essential members of the nursing team, they should be easily identified by patients – perhaps by wearing a standardised uniform, as has been recently introduced in Scotland and Wales.
- 14.3** The RCN believes statutory regulation for healthcare assistants is essential for patient safety and public protection. Furthermore, it is the RCN view that healthcare assistants who work alongside nurses in direct clinical care should be regulated by the nursing regulatory body. The RCN holds concerns over the introduction of the Independent Safeguarding Authority (the new public body charged with setting up a register of those that are considered to be fit to work with children and vulnerable adults in England, Wales and Northern Ireland) and does not believe this new body will resolve the need for healthcare assistants to be regulated.

**Royal College of Nursing
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