

# Royal College of Nursing

## Submission to the Prime Minister's Commission on Nursing and Midwifery

**Note:** *The Royal College of Nursing welcomes the opportunity to submit papers for the Prime Minister's Commission on the future of Nursing and Midwifery. Please note that the attached paper is one of five that the RCN has provided to the Commission to enable it to take forward its important work. Readers should be aware that there are a series of key themes and recommendations that run across all five documents submitted by the RCN and no individual paper should be considered in isolation. All the documents describe the role of the nurse now and in the future as well as commenting on the value of nursing, both qualitatively and economically, and its relationship with and influence upon wider society. When themes are covered in more than one paper we have included a cross reference wherever possible.*

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# A new vision of nursing and midwifery

Royal College of Nursing submission to the Prime  
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## A new vision of nursing and midwifery

### 1. Introduction

'We believe nurses and midwives have key and increasingly important roles to play in society's efforts to tackle public health challenges of our time, as well as ensuring the provision of high quality, accessible, equitable, efficient and sensitive services which ensure continuity of care, and address people's rights and changing needs'.<sup>1</sup>

The RCN wholeheartedly supports this statement and we wish, in our submission, to describe how it relates to the provision of nursing in England.

Nursing has a long and proud history of adapting to changes in society and its health needs, and responding to what the public wants from it. This was the case 100 years ago and continues to be so at the beginning of the 21<sup>st</sup> Century.

Society will not benefit from any attempt to reinvent nursing, but this paper highlights how nursing needs to adapt and develop if it is to continue to provide the full continuum of care in a rapidly changing world.

The provision of comprehensive and high-quality nursing demands constant vigilance, listening to the public and patients and taking appropriate action as a result of their feedback. Such action is the responsibility of the government, health managers, nurse educators and all other parts of the nursing profession.

### 2. Nursing as a diverse workforce

#### **Nurse executives**

Nurse executives have a complex, expanding and demanding role with a portfolio which requires expertise in strategic planning, business management and clinical care. Wider organisational concerns can often reduce the amount of time nurse executives have available to concentrate on the quality of care being provided within their organisation (OPM, 2006).

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.

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<sup>1</sup> W.H.O Munich Declaration 2000

In order to fulfil their responsibilities, nurse executives need the authority and ability to talk about the issues relating to the provision of excellent care, and their views must be respected and acted upon by the chief executive and other board members.

The chief executive should work with executive nurse directors to prioritise the inclusion of information from nurse executives on the standard of nursing provided in their organisation - from the care provided by the most junior of health care support workers, to that provided by consultant, specialist and advanced nurses.

It is essential for nurse executives to have access to comprehensive audit systems and data analysis, supported by robust reporting processes relating to the provision of high-quality care. Nurse executives are well placed to identify clinical risks and report on the management of risks within their organisation.

The ability, role and function of the nurse executive is critical to the success of a health care organisation and needs careful preparation, investment and support if it is to fulfil its potential.

### **Ward leadership**

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.<sup>2</sup>

### **Nursing students**

The decision has been made for graduate entry to the profession to be implemented across the UK by 2015 - meaning 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.

Pre-registration programmes need to relate closely to the demands of a modern health service which meets public expectations and reflects the ageing of the population. The NMC should take note of health policy challenges 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.

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<sup>2</sup> Breaking Down Barriers; Driving up standards: The role of the Ward Sister and Charge Nurse. The Royal College of Nursing 2009

If the profession is to attract high calibre mature students, we must address problems attached to childcare, bursaries and the 'passport' which would enable a student to transfer from one higher education institution (HEI) to another more easily when family commitments make this necessary.

The profession needs to move closer to multidisciplinary team working, while focussing on pathways of care, and being capable of moving quickly from one setting to another, in order to comply with patient needs and preferences.

Post-registration advanced and specialist nursing programmes will be at masters' level and beyond, and need to be equally accessible to nurses working in all areas of health care. Tax relief should be available to nurses who fund their own professional development programmes.

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 lucky 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.

### **Nurse educators**

This small group of highly experienced and qualified professionals is essential to the development of the present and future workforce and to the maintenance of high-quality care through their delivery of advanced programmes to the nursing/health care workforce.

Most nurse educators work in universities where recruitment would be easier if, like for medical colleagues there was free movement of pensions between the NHS and HEI, and 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 also be offered to enable these lecturers to undertake doctoral programmes, such as professional doctorates, which enable them to lecture in theory and practice at the highest possible level.

A smaller number of nurse educators work in further education colleges and as practice educators and in other teaching roles in trusts. It is important to the provision of high-quality nursing that these staff too need salaries which reflect their value and access to personal and professional development.

### **Health care support workers (HCSWs) and assistant practitioners (APs)**

Well-trained and supported HCSWs and, increasingly, APs are core to the delivery of safe and effective care in all health care settings. 200,000 nurses

are due to retire in the next decade<sup>3</sup>. This begs the question: where will our nursing workforce come from in the future? This is against the backdrop that many young people do not perceive nursing as a suitable career option. With an ageing population in the UK, people are living longer and developing a number of long-term conditions that will require care in the community: the challenge is to develop a suitably trained and educated nursing workforce that is able to deliver continuous quality improvements to patient care.

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 HCSWs and APs 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.

HCSWs and APs contribute to the:

- clinical nursing needs of children and young people with learning disabilities, as well as those with physical or sensory disabilities or communication impairments
- emotional, psychological and mental health needs of children and young people within the context in which they live
- needs of vulnerable children and young people, i.e. those who are at risk of significant harm from abuse and/or neglect, experience domestic violence or are in care
- needs of children and young people at the point of transition to adult services.

Shared education across the wider children and young people's workforce will begin at undergraduate level to ensure all practitioners have core competences underpinning knowledge, skills to support healthy child development, and to fulfil child protection and safeguarding responsibilities.

In schools, young people will be introduced to the National Career Framework so that they can see the range of entry points into a nursing career pathway, this being inclusive of the HCSW and AP roles.

Young people will see HCSW and AP roles as important roles for beginning a career in health care, and will easily be able to access vocational training, apprenticeships and foundation degree programmes. There will be easily

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<sup>3</sup> Peter Carter, Chief Executive and General Secretary of the RCN 2009

accessible funding streams to support the education and training of this workforce, and funded opportunities for HCSWs and APs to continue up the career pathway to undertake registered nurse training. Instead of HCSWs and APs being seen as a separate career pathway, it will be seen as integral to nursing, and a significant number of registered nurses will begin their career via this pathway. Many people will want the opportunity to step on and off the career escalator.

Education and training programmes will be developed around the competences developed by Skills for Health, so that anyone carrying out the competence can undertake the training related to it. This would mean that all health care staff, including those on a register, would undertake shared education and training, rather than the current practice of working in professional silos. This would help to break down barriers between staff and ensure that people understood and valued each other's roles.

HCSWs and APs will always have their work delegated to them by a clinician working at Level 5 or above on the National Career Framework. There will be a UK-wide recognised decision-making process on how to decide which tasks to delegate to HCSWs and APs. This will make redundant any need for employers and others to prescribe a specific list of tasks for HCSWs and APs to be 'allowed' to undertake. It will enable senior clinicians to decide what is appropriate to delegate in their context of care, and to really utilise this workforce.

HCSWs and APs will be carrying out a wide variety of roles in the acute and primary care settings: from undertaking simple tasks such as venepuncture and ECG, to complex tasks such as administration of the influenza vaccine, catheterisation and managing stable renal patients who are to undergo renal dialysis, administration of B12, depo injections, and will have a major role in health promotion and public health.

Without adequate investment in all parts of the nursing workforce, health care organisations will continue to struggle with staff shortages, poor skill mix, bed pressures, preventable morbidity and mortality, and poor provision of community health services.

Nursing is also put under pressure when management assumes that nurses will "fill the gap" whenever there is one to be filled, be it doctor, cleaner or administrator. Gaps in the provision of non-nursing activities put yet more pressure on nurses, and result in nursing care being compromised. Nurse executives should have the authority to prevent this from happening, making it necessary for there to be a statutory requirement for all health organisations to have a nurse executive on its board. We must strive for adequate investment in staff and more intelligent workforce planning,

## **Advanced and specialist nursing**

For a number of years, nurses have worked at the forefront of delivering more specialised, high-quality nursing care to increasing proportions of acutely ill patients and those with long-term conditions. Areas of practice include critical care/high dependency, urgent and emergency care, trauma and orthopaedic, ENT/maxillo facial, ophthalmic, imaging, surgical and operating theatres, acute medical specialties (cardiac, respiratory, neurological conditions, stroke, metabolic, liver, renal), haematology, haemophilia, blood transfusion therapies and cancer care.

Such highly-skilled nursing can only continue with the constant provision of education and training, which is often curtailed whenever financial savings need to be made. Nurses' education and training should be enhanced with protected, adequate and credible training accounts (in line with medical training accounts for senior medical staff).

Future health care will also demand that we provide nursing in non-typical settings, e.g. custodial areas, hostels for people who have no permanent address and in places where nurses are required to work with people in the sex industry.

In the last decade, nurses have emerged as key innovators in the development of improved pathways of care, further enhancing the patient experience and health improvement. Examples include critical care outreach, which happens both in the hospital and community; minor Injuries and ailments; older people's services; intravenous therapy specialists; surgical pre-operative assessment; acute pain services; ophthalmic services; orthopaedic clinics; colo-rectal clinics and outpatient clinics. Nurses are frequently providing these high-quality and cost effective services alongside, or as an alternative to, more conventional (medical) models. The RCN wishes such innovation to continue, in line with public needs, wishes and expectations.

The further development of nursing practice will enable the delivery of excellent care pathways, many of which could include care across acute and community care settings. Examples include respiratory, cardiac, diabetes, urgent and emergency care, medical admissions, vascular assessment, ENT, ophthalmic, gastroenterology and stoma care practitioners.

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 byword 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

specialties. Sadly, and to the detriment of patient care, the contribution of nurse leadership and nursing is often under valued by NHS Managers.

Greater emphasis must be placed on the further development of executive nurses, matrons, ward sisters/charge nurses, specialist and advanced practitioners and nurse consultants as clinical leaders. We must also adequately prepare the nurse educators of the future, so that, as a group, they are well placed to prepare our nurses to meet 21<sup>st</sup> Century health challenges.

### **3. Nursing across specialities and contexts**

#### **Nurses, children and young people**

Nurses caring for children and young people will increasingly work in the community, rather than the hospital. Further advances in genetics and technology, and the introduction of new vaccinations will result in a substantial reduction in the need for children to be hospitalised. The majority of surgery will be undertaken on a day-care basis, with follow-up support provided by community children's nurses at home. There will be a significant decrease in the number of children's inpatient units (possibly a reduction by as much as 50% over the next 10 years), with a substantial increase in the availability of community children's nurses and the number of children's assessment and short stay/observation beds, which will be led and staffed by advanced children's nurse practitioners. Inpatient provision will centre on specialist, hi-tech areas, predominantly neonatal and children's intensive care and step down facilities. Most care will be provided in areas outside of an acute inpatient environment.

The children's and young people's nursing workforce must have the ability to provide proactive universal services and be able to respond to children with acute or complex needs, regardless of the setting in which care is taking place.

Community children's nursing teams will encompass provision for prevention and health promotion, acute and unscheduled care and interventions, children's learning disabilities, children's mental health, long-term conditions, palliative and end of life care, short stay and respite care, complex health care needs, transition and co-ordination with the team around the child/ young person.

Children and young people will increasingly have diverse needs across a range of settings, demanding nurses capable of working across settings and boundaries. Health service provision will increasingly be provided in an integrated way with and alongside social care, education and the voluntary sector. Many health care teams will be led by advanced children's nurse practitioners and nurse consultants, with referral pathways to paediatricians who are engaged on a 'consultancy' basis.

Pathways for children's and young people's services will include acute and urgent care services, neonatal services, CYP mental health, long-term conditions and specialist services. Each pathway of care will encompass prevention, identification, assessment, interventions and long-term support. This means both basing services around the patient journey and taking a whole system approach to the commissioning, delivery and regulation of services. Children's nurses along the pathways will increasingly prescribe, undertake clinical assessments, diagnose, interpret X-rays and diagnostic imaging, plan and evaluate treatment, discharge and provide follow-up care without reference to a medical practitioner.

### **Nurses, mental health and learning disabilities**

Mental health nurses are now practicing in the post-asylum era with confidence and competence. The introduction of mental health nurse education in universities has witnessed the growth of academic departments, professorial chairs in mental health nursing, and a vigorous research programme focussed on client need.

All nurses and HCSWs should have basic skills and understanding of the special needs of patients with mental health problems and learning disabilities, regardless of setting.

Formal education programmes for mental health nurses will continue to develop the current process of involving clients in the selection of undergraduates, staff recruitment and the teaching and assessment of students. The parity long sought with other nursing areas has been largely achieved and will continue to be achieved in the future, resulting in ongoing health improvement for patients.

This will be promoted through client work with developments, such as liaison psychiatry – and an emphasis on making general hospitals 'mental health friendly' in their dealings with clients, carers and families.

The advent of community mental health services has seen a range of modern interventions such as assertive outreach teams, home treatment teams, crisis resolution teams, home detoxification and early intervention services. All of these new ways of delivering services to clients have been primarily led by nurses. Achieving progress in mental health demands that mental health nurses offer their services to prisoners, school children and in primary care.

Mental health nursing is well-placed to contribute to developing more personalised health care, partnerships with the independent and charitable sector, and expanded roles to meet changing health care needs and the ageing of the population in a variety of settings.

New roles such as nurse consultant, modern matron and the roles introduced in the revision of the Mental Health Act have seen mental health nursing advance to levels of more autonomous practice that will deliver improved services. Further nurse-led services will emerge which are underpinned by advances in practice, such as diagnosis and independent prescribing.

Mental health nurses interventions with clients, carers and families will be informed by the Recovery model. This will be characterised by the instillation of hope and a shift away from a reductionist model which focuses on deficits and chronicity. They will be adept in providing psychological and psychosocial skills to care and treat people with complex, acute and long term mental health problems. Nurses are already championing the development of new services in areas of obesity, alcohol and drug use, early detection of mental health problems and the promotion of wellbeing.

Mental health nurses will be engaged in the care and treatment of individuals across the life span. The growing numbers of older people will see mental health nurses taking a lead in memory clinics and guiding other workers and family carers on the care and treatment of people with dementia.

Workforce issues, such as the large number of nurses who will shortly retire, clearly have relevance to mental health nurses. However, mental health nursing has always recruited away from the traditional manner of other branches of nursing. The recruitment of mature students into undergraduate programmes will continue and grow. Accepting individuals who have personal experience of mental health services will continue to enhance educational programmes, and ultimately the services offered.

Recent reports have highlighted the special health care needs of those people with learning disabilities (LD). They also described the unacceptable and poor standards of care received by patients with LD while in hospital.

The future demands that we are able to provide more, and much improved care for people with LD. Premature babies often survive, but with long-term complex needs. People who have learning disabilities are living longer, well into old age and increasingly outliving their parents who have been the main carers.

People who have learning disabilities are now no longer living in NHS or other institutions, but in the community where they are supported by a range of community services.

The RCN supports the call to improve the care of people with LD through the appointment of specialist LD nurses in hospitals. In the community, LD nurses provide a critical role in supporting people to improve their health and quality of life.

## **Nursing in the community**

Transforming Community Services is an essential and ambitious direction of travel for future health services, and has profound implications for nursing. Nurses have always worked closely with people to help them improve their health and quality of life, and will continue to do so regardless of changing health patterns, health problems and new technologies. TCS further emphasises this.

Historically, hospitals have employed 80% of the nursing population, and the community 20%, which must radically shift if the TCS aspirations are to be achieved.

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. The training and education of nurses has to change, so that it prepares them (on registration) to function equally competently in the community and the hospital and to work with an increasingly ageing patient group. While it is ludicrous to suggest that we will no longer need to prepare nurses for the hospital, we certainly need to seriously consider what action needs to take place to ensure that we prepare both the correct number, and appropriately educated nurses to work in the community.

Future nurses will think and act public health at the same time as providing care for patients. The NHS has, historically, cared well for people once they become ill, but has been less well-equipped for helping people stay well and not needing health care. Nursing must play a significant part in the public health movement, take the lead as well as centre stage. Public health must have the respect it deserves from both the public and politicians.

We can do far more to encourage people such as school leavers and mature students to enter the nursing profession. An ideal media campaign would highlight not only the wonderful care provided by hospital nurses, but also the work that is currently carried out by nurses working in the community. Nursing is a wonderful career for life, it is global and offers exciting opportunities in ground breaking technology and research.

New technologies which will continue to be developed, mean much of the care being provided in the intensive care unit can now be provided safely within a patient's bedroom. However, this is neither a cheap nor an easy option and the implications will have to be more fully considered as we progress.

Acute and intensive nursing can easily be provided with safety and quality in the community by those nurses who have received adequate preparation and education and who are supported in developing advanced skills. The public

need to understand their health and wellbeing does not depend upon the local hospital, but can be enhanced by having access to well-developed and comprehensive community nursing services.

Robust public health nursing, integrated with community nursing and general practice, is a vision that many community nurses have wanted to see in place for many years. Various health reforms over the years have, for the main part, failed to significantly enhance public health and community nursing services, but we need to believe that TCS will significantly change future health care.

The vision for nursing in the community is in 10 years time:

1. 80% of the nursing workforce will be working with local people to improve their health, rather than working in the hospital fixing the preventable
2. pre-registration nursing courses will prepare a nurse to be able to function equally well in the community and hospital
3. local health organisations will employ public health nurses who work with colleagues to engage in community development and health improvement programmes
4. it will be normal for acutely ill patients to be cared for in their own homes
5. people will expect to die at home, receiving all necessary care and attention from appropriately prepared nurses
6. community nursing will be a popular career for talented nurses
7. community nurses will have played an enormous part in improving the health of people living in England, resulting in the safe reduction of a large number of hospital beds.

### **Midwifery and women's health services**

Maternity wards are often confusing places for women, especially those experiencing childbirth for the first time. Sadly, some experiences of antenatal labour and postnatal care are of poor quality. Media reports today highlight "not enough midwives, staffing levels are low and new skills are needed to work in hospitals"<sup>4</sup>

The RCN believes that midwives, like nurses, need to be educated to degree level to ensure that their practice is underpinned by both evidence and excellence.

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<sup>4</sup> RCM 2009

While hospitals are becoming less attractive place for midwives to work in, there is a positive move towards the concept of working in a poly clinic or other primary health care setting, as cited in Lord Darzi's report.

Midwives should be given the opportunity to set up, run and manage maternity centres in their communities based on the needs and wishes of local people. Providing home-based women and children's health care services should also be considered.

The role of the midwife is expanding beyond care for a woman in normal labour, and midwives sometimes straddle two posts, one in midwifery and another in obstetrics. The expanding role of the midwife into health centres should be encouraged.

Developing midwifery services closer to home needs greater clarification, and should be addressed through joint contracting with Directors of Midwifery, PCTs and local authorities in partnership with a commercial concern.

### **Addressing diversity and equality in nursing**

Essential to and running through all of the above, should be a workforce that truly represents and reflects the values and culture of the people they serve. Where this happens successfully, health outcomes are positively affected and community engagement improved particularly for groups traditionally at risk of poor health through exclusion or lack of culturally sensitive services.

Recognition of, and respect for, diversity amongst staff can better equip the NHS and its partners to improve health in partnership with a diverse public<sup>5</sup>. Visible commitment to nurturing equality and diversity is important and can help the NHS and other employers in health and social care to comply with legislation and public policy; improve public image; and recruit and retain talented and motivated staff from different backgrounds.

In terms of leading service design and provision, attention should be paid to encouraging people from a diverse range of backgrounds to get involved in commissioning through LINKs and PPI groups; governance of Foundation Trusts; and seeking roles as Non-Executive Directors.

To develop a diverse and culturally aware workforce, opportunities to understand and respond to the individual needs of people from BME groups should be presented throughout the career pathway – from HCSWs to Chief Executives. The Mary Seacole award<sup>6</sup> has a proud history of celebrating and

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<sup>5</sup> RCN London (2006) *'Releasing the Potential Within BME Networks'*. London

<sup>6</sup> The Mary Seacole Leadership and Development Awards were developed out of the clear recognition that more needed to be done for black and minority ethnic (BME) nurses, health visitors and midwives in the NHS. The 2007 and 2008 awards were open to all in clinical practice in England with the

rewarding those who have made a particular contribution in that respect. At a local level, mentorship and support groups can encourage nurses from BME backgrounds to believe that they can make a difference.

We are particularly keen to see sustained progress in addressing inadequate representation at leadership levels<sup>7</sup> through the use of BME networks such as the RCN NHS BME Leadership Forum or the NHS Institute for Innovation and Improvement 'Breaking Through' program which seeks to support the development of advanced leadership and managerial skills for BME managers and clinicians to enable them to perform effectively at directorial level<sup>8</sup>.

## 8. Recommendations

The RCN's key recommendations are as follows:

- Service improvement demands that commissioners focus on patient care pathways, rather than commissioning different services in different settings. Examples of such approaches where care has been significantly improved as a result, include those pertaining to the management of strokes, and heart failure.<sup>9</sup>
- More could be done along the Nursing career pathway to ensure a visible commitment to nurturing equality and diversity in the workforce which can help the NHS and other employers in health and social care to comply with legislation and public policy; improve public image; and recruit and retain talented and motivated staff from BME and other different backgrounds. We are particularly keen to see sustained progress in addressing inadequate representation at leadership levels from amongst BME groups.
- The development of services, according to care pathways means that the nursing workforce must have transferable skills and knowledge, and be capable of caring for patients in both the hospital and community. Nurses will be mobile, always going where their patients happen to be, rather than being fixed in one building or institution.
- Nurse educators will need to be capable of preparing a nursing workforce which is able to safely transfer from one setting to another, and always providing high-quality care. Wherever people are receiving nursing, their care will be underpinned by all the elements which

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development awards, but not necessarily the leadership awards, focusing on health needs of BME population

<sup>7</sup> NHS Leadership Centre (2001) *'Getting on against the odds: how black and minority nurses can progress into leadership'*

<sup>8</sup> NHS Institute for Innovation and Improvement (2007) *'Breaking Through: Building a diverse leadership workforce'*

<sup>9</sup> Getting better: Using Stroke Services across the UK. Stroke Association 2009)

promote dignity, reassurance, positive health outcomes and safety. It is critical to patient safety that all nurses have an in depth understanding of the basic elements of care, eg post operative observations, nutrition and hydration, personal hygiene and record keeping.

- The 21<sup>st</sup> century nurse must have an understanding of public health and, regardless of their main place of work; promote health and equality; develop the skills and knowledge to work effectively with older people; take the right action to prevent disease and identify it at the earliest possible opportunity.
- 70% of health care is nursing, which is by far the major provider of care within the NHS and independent provider organisations. If health care organisations were committed to ensuring that nursing was well led, resourced and supported, it is likely that patients would be safe while in their care.
- It is essential for health care organisations to focus on the quality of all levels of nursing care, from fundamental and basic nursing through to specialist and advanced practice. Lives are saved and the patient experience improved when we ensure this happens, yet when finances have to be saved it is often nursing which is reduced before other disciplines. We must learn lessons from the Maidstone and Mid Staffordshire Hospital experiences.
- The highest quality care is provided at the least cost to the organisation. It is poor care which brings added financial burdens to the health care organisation. Money is not saved by reducing nursing numbers and diluting skill mix. Patient experience and health outcomes are improved through deploying adequate nurses and HCSWs at the appropriate skill mix to best meet patient needs. The RCN Ward Sister Project demonstrates the added value that well-prepared and supported ward leaders bring to patient care.
- The RCN supports the ambitions and aspirations of Transforming Community Services and is keen to work with the DH on its implementation.
- 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. We must constantly reflect on how the public sees nursing, what it expects from us and how we need to adapt to meet changing expectations and needs.

The profession needs to be seen as a vibrant, though challenging career by intelligent school leavers and mature potential students.

Basically, the public wishes to 'be safe in our hands', reassured when, as patients they experience frightening and distressing illness. Hospitals are emotionally charged and complex organisations where patients and their families experience the very best and worst of times.

Community nurses work closely with the public throughout all stages of life, from the very beginning through to providing excellent end of life care. Generally speaking people want more of community nursing than it is capable of giving. The public relies upon nurses when they are not capable of caring for themselves.

Compassionate care, competence, skill and knowledge are the characteristics of nursing which are valued by the public. The profession needs to feel confident that it is able to build on its very best and tackle current weakness and deficits which compromise the way the public values nursing.

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# Quality and innovation

Royal College of Nursing submission to the Prime Minister's Commission on Nursing and Midwifery

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## Quality and innovation

### 1. Quality and innovation: an RCN position

Nursing is about providing person-centred, effective and safe care as well as ensuring care systems sustain quality, safety and enable innovation. It includes ensuring continuity of care across pathways, boundaries and sectors as well as working in partnership with patients, clients and other key stakeholders<sup>1</sup>.

Quality and innovation are mutually dependent. An underpinning of what constitutes quality will be rooted in evidence and expert opinion. Innovation moves care, and the benchmarks by which it is measured forward. Innovation is both a product of a culture that provides quality care and an approach for continually improving quality driven by the health care needs of patients and clients<sup>2, 3</sup>. Nursing has a leading role in innovation as an approach to continually developing quality and this has been recognised by Darzi<sup>4</sup>.

The RCN recognises quality care by the presence of the following characteristics:

- care centred around the person and their health care needs (person-centred care)
- standards based on the best possible evidence, which support care that is safe and effective regardless of the care provider
- role clarity and the presence of the skill set necessary for developing and sustaining an effective workplace culture in the clinical/practice team as close to patient/client care as possible i.e. clinical leadership, skilled facilitation of learning in and from practice, systematic evaluation, evidence use and development, political acumen, managerial skills<sup>2</sup>
- organisational commitment to quality improvement through systems that sustain person-centred approaches, safety and effectiveness.

These structures, processes and ways of working include:

- learning in and from practice (work-based learning, using everyday work as the main resource for learning)

<sup>1</sup> RCN (2009) Measuring for Quality in Health Care. RCN website

<sup>2</sup> Manley et al (2007) Effective Workplace Culture concept analysis. RCN Workplace Resources for Practice Development . RCN London

<sup>3</sup> RCN (2007) RCN Workplace Culture: Standards for effective health care. In RCN Workplace Resources for Practice Development . RCN London

<sup>4</sup> McLellan Alastair (2009) Darzi calls on nurses to lead NMH innovation Nursing Times.Net 29/07/09

- evidence<sup>1</sup> use and development including research literacy, creating and interpreting evidence
  - systematic evaluation of practice and change, individual and team effectiveness
  - formal participation of all stakeholders in decision-making (shared governance) including active patient/client/carer involvement e.g. Principia – a social enterprise organisation based in Rushcliffe, Nottingham where the board has more members of the public than managers and professionals
- ongoing innovation and creativity is a component of an effective workplace culture<sup>2, 3</sup>, one that enables health care to respond to changing health care needs and contexts, as well as, being proactive in identifying more effective ways of providing care<sup>2</sup>.

Appropriate nursing establishment and skill-mix are major factors in enabling quality of care to be delivered<sup>4</sup>

Nurses across the career framework from health care assistant through to registration, advanced level practice and consultant practice first develop expertise in person-centred and effective care within the nurse-patient relationship before developing expertise in the skill-set necessary to develop systems that sustain quality, albeit, applied to different client groups and settings<sup>5</sup>.

Expertise in nursing practice has been shown to transform the lives of patients from the patient's experience<sup>6</sup>. Nurses working at the advanced practice level provide a significant cost-effective service in contributing to meeting health care needs with specialist and consultant nurses being linked to many innovations in care<sup>7, 8</sup>.

Nurses can be motivated and are willing to innovate – this has been recognised by Darzi<sup>9</sup>. However, there is a lack of clarity about what

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<sup>1</sup> 'Evidence' is used to encompass evidence from a range of different sources e.g., research, expertise, the patient and his/her experience, structured reflection and includes different formats e.g. standards, guidelines, audit, patient assessment data etc

<sup>2</sup> Manley et al (2007) Effective Workplace Culture concept analysis. RCN Workplace Resources for Practice Development . RCN London

<sup>3</sup> RCN (2007) RCN Workplace Culture: Standards for effective health care. In RCN Workplace Resources for Practice Development . RCN London

<sup>4</sup> Rafferty, AM et al, Outcomes of variation in hospital nurse staffing in English Hospitals: Cross section analysis of survey data and discharge record. international journal of Nursing Studies (2006) doi:10.1016/j.ijnurstu.2006.08.003

<sup>5</sup> RCN (2009) Integrated core competence and career framework for registered nurses. RCN Competences, RCN London

<sup>6</sup> Manley K, Hardy S, Titchen A, Garbett R, McCormack B (2005) Changing patients' worlds through nursing practice expertise. Exploring nursing practice expertise through emancipatory action research and fourth generation evaluation. A Royal College of Nursing Research Report 1998-2004. RCN London

<sup>7</sup> Maxi nurses: advanced and specialist nursing roles. Results from a survey of RCN members in advanced specialist roles. Jane Ball, RCN London 2005

<sup>8</sup> Richard Hatchett (2003) Nurse led clinics: practice issues, Routledge

<sup>9</sup> McLellan Alastair (2009) Darzi calls on nurses to lead NMH innovation Nursing Times.Net 29/07/09

constitutes innovation and how decisions are made regarding which 'innovations' to pursue. The current emphasis on relying on the evidence base might be hampering the sharing of innovative ideas. Given that in many areas the evidence base itself is limited, this issue requires further clarification.

An effective mobile nursing workforce will require both a robust communications infrastructure – electronic records, access to knowledge sources, telehealth, telecare – and the capacity to use it.

## **2. Current barriers to quality and innovation and how they can be overcome**

### **Workplace culture and clinical leadership**

Negative, ineffective or toxic workplace cultures were recognised in the Bristol Royal Infirmary report and report into both Mid Staffs and Maidstone and Tunbridge Wells as the cause of systems failure<sup>1</sup>. Such cultures are still experienced by staff and patients, with poor quality care recognised by:

- staff who are de-motivated and uncommitted, do not feel valued, perceive they have no voice or feel frightened to speak up
- 'hamster-wheel' activities, where ways of working and behaviours are taken for granted and remain unchallenged. Time and clinical supervision is not provided to enable nurses to reflect on how they can work more smartly and effectively
- lack of a learning culture, professional development, clinical supervision, and instead a focus on blame
- lack of systematic evaluation and review of both individual and team practice
- unclear values, direction, roles and responsibilities
- insufficient numbers of expert nurses and staff
- poor patient experiences and outcomes.

The most influential factor on workplace culture is clinical leadership particularly transformational leadership<sup>2</sup>. Therefore a need continues for ongoing investment in clinical leadership and continuing support for clinical

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<sup>1</sup> RCN (2001) *Learning the lessons* A summary of the RCN's response to the Bristol Inquiry, RCN, London: Bristol; Commission report on outbreaks of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust 2007; RCN media announcement 24 March 2009 Mid-Staffs driven by finance not patient care, RCN

<sup>2</sup> Manley et al (2007) *Effective Workplace Culture concept analysis*. RCN Workplace Resources for Practice Development . RCN London

leaders in their everyday work<sup>1, 2</sup> This support is especially valuable when provided by other senior nurses who have expertise in managing complex areas e.g. modern matrons or consultant nurses with their expertise in developing and evaluating person-centred systems across patient pathways.

In addition, having the right number of registered and expert nurses in practice is a key priority if quality and innovation across health care is to be achieved as well as freeing up the ward sister's role from unnecessary administrative and managerial tasks so that they can quality assure practice.

### **Organisational culture**

Whilst the workplace culture has a direct impact on quality and innovation, the organisational culture too exerts an influence. Many barriers to quality can be addressed by individuals and teams at local level, however, there is a need for pervasive barriers to be acknowledged and addressed at organisational level by managerial and nurse leaders.

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 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.

Attention needs to be given to the delivery of quality and safety in care rather than focus solely on throughput 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.

Enabling strategies that organisations can use include:

- ensuring senior managers are visible and understand and experience the day to day provision of health care
- combining targets with a culture that enables innovation and creativity

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<sup>1</sup> Large S et al (2005) A multiple-case study evaluation of the RCN Clinical Leadership Programme in England, RCN London

<sup>2</sup> RCN (2009) Breaking down barriers, driving up standards – the role of the ward sister and charge nurse, RCN London

- 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 nurse in providing quality care
- working with professional organisations and patient/ public representatives to focus attention on the relevant issues, and potential solutions.

**Clinical career ladder that positions the skills and expertise required for quality and innovation, and the skills required for enabling an effective workplace culture, to be developed and sustained**

The current clinical career ladder, both pre-registration and post-registration, needs to have at its heart person-centred, effective and safe care if quality and innovation is to be achieved and sustained for the future by nurses.

The development and retention of nursing expertise in the practice environment is vital for enabling quality of care to be expressed by credible role models who are highly respected by patients and staff. The RCN's Expertise in Practice project showed that patients recognised the value of expert nurses<sup>1</sup>, and research on consultant nurse practice demonstrated the positive outcomes of ensuring that expertise in developing person-centred systems was required to develop an effective workplace culture and that these skills needed to be as near to the nurse-patient interface as possible<sup>2</sup>. The need for skilled facilitation using participative, collaborative and inclusive approaches to enable learning in and from practice; implementation of evidence and standards into practice; ongoing evaluation of individual and team effectiveness; and implementation of shared values, reflects the additional skill-set expected of posts with a remit for practice development<sup>3</sup>. These processes have been linked to positive outcomes such as quality of care, effective cultures, increased competence and greater commitment as well as improved services<sup>4</sup>.

<sup>1</sup> Manley K, Hardy S, Titchen A, Garbett R, McCormack B (2005) Changing patients' worlds through nursing practice expertise. Exploring nursing practice expertise through emancipatory action research and fourth generation evaluation. A Royal College of Nursing Research Report 1998-2004. RCN London

<sup>2</sup> Manley K (2001) Consultant nurse; concept, processes, outcome. Unpublished PhD RCN Institute London/ University of Manchester

<sup>3</sup> Manley K & Webster J (2006) Can we keep quality alive? *Nursing Standard* Sept 27<sup>th</sup> 21(3) pp 12-15

<sup>4</sup> McCormack, B., Dewar, B., Wright, J., Garbett, R., Harvey, G. and Ballantine, K. (2006) *A realist synthesis of evidence relating to practice development: executive summary*. NHS Quality Improvement. Scotland. ([www.nes.scot.nhs.uk/](http://www.nes.scot.nhs.uk/))

There is a need to promote with greater clarity:

- influencing the commissioning process to recognise how advanced and consultant nurses achieve whole systems approaches<sup>1</sup> and person-centred systems and enable quality and innovation to take place
- how nurses working in specialist and advanced level roles address health care needs by developing new services or expanding services in a cost-effective way<sup>2</sup>
- how nurses and health care assistants are quality assured against relevant and appropriate standards significant to patients and users

It is essential that the clinical career framework has as its backbone the development of expertise in person-centred, safe and effective care, progressing to the developing expertise in person-centred systems needed to sustain quality. The clinical career framework also needs to interface with the clinical academic career pathway so that the centrality of quality care is underpinned by quality evidence.

At the other end of the career framework it is essential that health care assistants have a clear pathway into nursing that is based on developing expertise in the essence or fundamentals of care, and have the support of sufficient registered staff to foster their development in the workplace.

A greater focus on work-based learning will enable practitioners to integrate life-long learning, and inquiry for the benefits of 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'<sup>3</sup>.

### **Accessing accredited information, evidence and standards to inform effective practice**

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<sup>1</sup> "The Whole system is not simply a collection of organisations which need to work together, but a mix of different people, professions, services and buildings which have patients and users as their unifying concern, and deliver a range of services in a variety of settings to provide the right care, in the right place at the right time" (Department of Health 2003).

<sup>2</sup> Maxi nurses: advanced and specialist nursing roles. Results from a survey of RCN members in advanced and specialist roles. Jane Ball, RCN London 2005

<sup>3</sup> 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

The quality agenda places an increased emphasis on information and information management. This requires a) appropriate engagement with the e-Health agenda at all levels of nursing, from health care assistants to nurse executives, and b) adequate investment in the systems and processes that support effective information management, from education and training to technical standards and practice guidance.

A set of standards that reflect the essential care that nurses are responsible for providing may assist in ensuring organisational support for appropriate nursing staffing levels, appropriate professional development and acknowledgment of nursing insight and expertise when nurses raise concerns about care. For example the basis of this approach has been demonstrated in Blackpool<sup>1</sup>. This will need to be accompanied by more work exploring and building up the evidence base on the relationship between the nurse's contribution to process and eventual outcomes.

Measurement that reflects the contribution of nursing to quality care needs more exploration. Whilst the recent Griffiths paper<sup>2</sup> promoted the use of outcome measures, which is logical and valid, it may be that some process measures would also be worthy of consideration. Areas of care such as tissue viability, falls and failure to rescue feature in many current activities relating to metrics and are worthy of consideration, but other areas of care may also merit further investigation.

Nurses will need easy access to 'just in time' sources of information to support care decisions in rapidly moving environments as well as accredited nursing evidence and standards.

### **Evaluating and measuring care**

Whilst benchmarks such as Essence of Care in England and Fundamentals of Care in Wales exist, there is a need to help nurses to be clear of the standards expected of them. A systematic approach to evaluation and development of their practice helps them to demonstrate their ongoing effectiveness. This requires a set of standards across the UK that focus on everyday activity; that the public can recognise and value; and that all nurses are expected to meet. Further work is required on making such a set of consensual standards explicit; taking forward the identification of criteria, indicators and measures linked with the electronic health record; and a standardised language that enables the contribution and effectiveness of nursing to be judged. These measures need to focus on the basics as well as the promotion of health and wellbeing. Further commissioned research and development is required into the processes that enable transformation of

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<sup>1</sup> Nursingtimes.net One of England's largest foundation trusts set to roll out system of nursing metrics. Nursing Times [www.nursingtimes.net/whats-new-in-nursing/one-of-englands-largest-foundation-trusts-set-to-roll-out-system-of-nursing-metrics/1975064.article](http://www.nursingtimes.net/whats-new-in-nursing/one-of-englands-largest-foundation-trusts-set-to-roll-out-system-of-nursing-metrics/1975064.article) viewed 06/08/09

<sup>2</sup> Griffiths P; Jones S; Maben J; Murrells T (2008) 'State of the art metrics for nursing: a rapid appraisal. Kings College, London.

practice and innovation. Investment in the evidence base on the impact of and nursing in all sectors is also required.

### **Sufficient numbers of appropriately registered and expert nurses**

There is growing acknowledgment that skill mix and staffing ratios impact on the ability of staff to provide safe and effective care. There needs to be more work to establish good mechanisms to set and maintain appropriate staffing levels. Factors such as nursing interpretation of patient acuity levels need also to be further explored in relation to making 'real time' judgements about the required staffing composition to provide safe and effective care. There needs to be a refocusing of policy to enable nurses to be free to provide direct care.

Establishment and skill-mix guidelines are required to reflect the dependency of patients and the technology used that are accepted by the profession and regulators so as to provide stability and sustainability to health care providers and professionals.

### **Direct involvement of nursing at the highest levels of commissioning and policy development around quality**

Direct nursing involvement in the development of standards for quality and commissioning processes as well as greater opportunities for influence at policy and strategic health authority level around quality and innovation are required. This will enable nursing expertise around quality and person-centred systems to have greater impact.

Nursing expertise is required at all levels of governance and policy making to be both visible and valued as a crucial apex for delivery of quality nursing care<sup>1</sup>.

## **3. Moving forward the patient experience, safe and effective care**

### **Experience of care**

Effective, person-centred care results from an informed dialogue between nurses and patients. Co-constructing of plans for care between nurse and patients is central to addressing expectations and formulating shared goals. There is some evidence of the impact of this but also a need for more research.

Advanced and specialist nurses have been shown to have a positive impact on the patients experience of care and again more research is needed to add to the evidence on this. The wide range of titles and roles at this level need to be addressed as at present the lack of clear definitions hampers understanding and comparability.

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<sup>1</sup>Machell S et al (2009), From ward to board: Identifying good practice in the business of caring. Kings Fund and Burdett Trust

The patient experience of care needs to be understood to support 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.

Patient reported outcome measures may be useful in terms of reflecting the impact of nurses and nursing especially around safe, effective and person centred approaches to care which meet patient's expectations and needs.

There needs to be greater stability in the system to enable these types of approach to flourish.

### **Safety and effectiveness of care**

Nurses have a pivotal role in driving the safety and effectiveness of care. They often 'hold the ring' on diverse clinical and other information and frequently act as case managers. They need skill in decision making and keen insights into systems and processes in order to deploy information effectively and appropriately across the multidisciplinary team.

Person-centred systems of care require continuity, integration and whole systems approaches. A greater emphasis on the patient's experience of continuity of care as the basis to inform system improvement is needed.

The use of information technology is increasing in health care but nursing issues need to be considered more strongly in the development stages as well as roll out. An electronic patient record which reflects nursing care and not simply a medical model has the potential to revolutionise nursing care around the patients' journey. It also feeds into the availability of data which may contribute to systems for evaluation, learning and shared governance. This needs to be better researched, understood and more evidence gathered around it.

Nurses contribute to the overall culture within the workplace particularly through leadership and facilitation. This can be positive and drive effectiveness and is especially true of many expert nurses and consultant nurses who act as role models and innovators. Similarly nurse led units have been shown to make a difference for patients.

Nurses working at the advanced practice level can provide a significant cost-effective service in contributing to meeting health care needs, and expert nursing is felt to transform the lives of patients. The skill-set develops across the career framework from an initial focus on individual clients through to expertise in patient-centred systems seen in the consultant nurse. There is a need to support this development with clear, well supported career frameworks that include ongoing quality assurance of practice at every level. Educational preparation needs to include the key skills alluded to earlier, it also needs to ensure work-based learning is incorporated.

#### **4. Conclusion**

Nursing in its purpose and focus on person-centred, effective and safe care, as well as developing and sustaining whole systems approaches is more closely aligned to the quality and innovation agenda than any other profession. Nursing therefore has the expertise to justify a leading role. However, this expertise in the past has been far too implicit and has not been adequately acknowledged and celebrated. For nursing to play a more explicit and leading role there is a need to:

- a) make quality, safety and innovation the backbone of the career framework
- b) invest further in clinical leadership and the clinical career ladder to ensure that sufficient nursing expertise is retained in the workplace where it can directly impact on quality
- c) develop and promote nursing standards and evidence more extensively, integrating it into the electronic patient record
- d) position nursing expertise at higher levels of influence in commissioning and policy.

#### **5. Recommendations**

The RCN's key recommendations are as follows:

- i. **Make quality, safety and innovation the backbone of the career framework**
  - a. Implement a curriculum at pre-registration and then post-registration that focuses on the essential standards for the fundamentals of care expected of all nurses and then the development of expertise in person-centred, safe and effective practice.
  - b. Implement a curriculum post –registration that integrates movement towards advanced and consultant nurse practice that focuses on sustaining the provision of quality fundamental care by nursing, as well as, developing expertise in person-centred and whole systems approaches and the facilitation of this in others.
  - c. Implement work-based learning<sup>1</sup>, linked with clinical supervision as a key approach for enabling nurses to continue to provide the

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<sup>1</sup> Everyday work of healthcare is the basis for learning, development (including evidence implementation), inquiry and transformation in the workplace.' (Manley K; Titchen, A; Hardy S (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)

fundamentals of care as well as grow their expertise, provide quality, safe and effective care and thus the achievement of both professional and academic accreditation.

- d. Consider approaches to the quality assurance/revalidation of nursing practice that have at their heart the essential and fundamental aspects of nursing as well as advanced and consultant nurse practice.
- ii. **Invest further in clinical leadership and the clinical career ladder to ensure that sufficient nursing expertise is retained in the workplace where it can directly impact on quality**
    - Free up the ward sister to enable a greater quality assurance role in relation to the provision of essential nursing care and the clinical supervision of the nursing team.
    - Provide clinical supervision to ward sisters by modern matrons, and consultant nurses to enable continuity of support around their leadership and management role.
    - Continue to invest in clinical leadership and the development of expertise in nursing that focuses upon improving the quality of care and reducing patient safety incidents.
    - Need for skilled facilitators with the required skill-set to be as near as the interface with patients as possible to enable learning in and from practice, implementation of evidence and standards into practice, individual and team effectiveness, implementation of shared values.
    - Systems for systematic evaluation, learning in and from practice and shared governance<sup>1</sup> need to be implemented at the workplace level.
  - iii. **Develop and promote nursing standards and evidence more extensively, integrating it into the electronic patient record**
    - a. Develop standards for the essentials of nursing care and related measures to enable quality of nursing to be judged and the impact of nursing to be articulated.
    - b. Ensure nurses have access to relevant information in the workplace.

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<sup>1</sup> Shared governance encompasses achieving stakeholder participation in using evidence from a variety of sources (e.g. audit, feedback, reflective practice, research) for decision-making

- c. Develop electronic health records that integrate nursing standards, standard terminology and data for measuring quality.
  - d. Develop more explicit position on the number and quality of nurses required and commission further research in this area (see paper on socio-economic case for nursing).
- iv. **Position nursing expertise at higher levels of influence in commissioning and policy**
- a. Ensure nursing expertise at all levels of governance and policy making is both visible and valued as a crucial apex for delivery of quality nursing care and innovation.
  - b. Acknowledge and provide incentives for creativity, innovation and improvements in patient care.
  - c. Commission more research on how quality and innovation is better spread and mainstreamed.

# Helping and hindering forces

Royal College of Nursing submission to the Prime  
Minister's Commission on Nursing and Midwifery

**Note:** *The Royal College of Nursing welcomes the opportunity to submit papers for the Prime Minister's Commission on the future of Nursing and Midwifery. Please note that the attached paper is one of five that the RCN has provided to the Commission to enable it to take forward its important work. Readers should be aware that there are a series of key themes and recommendations that run across all five documents submitted by the RCN and no individual paper should be considered in isolation. All the documents describe the role of the nurse now and in the future as well as commenting on the value of nursing, both qualitatively and economically, and its relationship with and influence upon wider society. When themes are covered in more than one paper we have included a cross reference wherever possible.*

## Helping and hindering forces

### 1. Introduction

This paper will explore the forces that can help or hinder (or both) the future direction of nurses and nursing in the context of the NHS. It will discuss the impact, both real and potential on nurses and nursing in a changing environment of health care.

Throughout the accompanying papers, the challenges and opportunities for nurses and nursing have been highlighted. Some of the issues raised in this paper are similar to those in previous papers; however some of them are different and in many cases are highlighted as both helping and hindering forces at the same time.

### 2. Nursing leadership

The RCN believes that the nursing leadership role is one that creates a strong and unified culture that is able to both focus on current patient care but also future innovations to improve it. The RCN has recently explored the ward leadership role and we know that similar roles exist in community and primary care settings. This clinical leadership role has been described as *multidimensional* in that it combines clinical practice, management of care delivery and the ward environment with education.

**This is a complex role in a complex environment and we have re-iterated our call for an urgent review into the ward sister role together with investment in their training and development.**

**The RCN also calls for a review of the nursing team leadership role in community and primary care settings and an assurance of investment in their training and development as a pre-requisite to taking up post.**

There is plenty of research evidence, both inside the NHS and outside of it, that confirms the link between leadership and effective team working. There is additional evidence that in health care it is effective teams that enhance the ability to deliver high-quality health care that supports innovation in practice. However, we have argued in a previous paper that nurse leadership, across and within an organisation is key to its success and that ultimately effective teams develop as a result of clear leadership (Borrill and West 2002)<sup>1</sup>.

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<sup>1</sup> Borrill C & West M (2002) *Team Working and Effectiveness in Health Care: Findings from the Health Care Team Effectiveness Project*, Birmingham: Aston Centre for Health Service Organisation Research

Investment in the leadership development of nurses is crucial in all contexts in the health sector and particularly important for those nurses who work across what we generally refer to as 'traditional boundaries', different teams and various organisations in the pursuit of developing and delivering high-quality, patient-focused services. Due to workforce changes over the years we have witnessed a sea change in the make up of teams, and nurses are increasingly taking on leadership and management roles of increasingly multi-skilled groups of staff. We need nurses who can work across organisations, create strong collaborations, develop patient care pathways and secure innovative services that meet identified health needs and that empower patients. In addition to this we also need nurses who are responsible for working with, educating and directing patients rather than caring for them especially as we see a rise in long-term conditions and continuing poor health behaviours.

**The RCN calls for greater investment in the education, training, learning and development of nurses that prepares them for the 21<sup>st</sup> century and beyond that will ensure a skilled and well-prepared workforce.**

**Specifically we require investment in nurses' team leadership skills, to equip them to effectively lead and manage skill mix in multi-disciplinary teams, in both primary and secondary care settings.**

**Understanding the wider determinants of public health** – nurses working in out-of-hospital community settings have always worked in a way that takes account of the factors that impact on people's lives and that are not within the domain of health. We are acutely aware of the changes to the health of the population, mostly attributable to health (or unhealthy) behaviours, and the widening gap in health inequalities, and we know that many nurses are changing and adapting their roles to meet the new patient centred pathways of care that require them to work in a very different way in a variety of settings. Many of these settings will be based in communities where people live and nurses are taking on the leadership challenge of developing responsive services that meet the needs of the most disadvantaged, such as homeless young people, asylum seekers, those suffering domestic abuse, child protection to name a few. Nurses should be enabled to become confident, skilled practitioners and to develop a greater understanding of the factors that influence how people live their lives and what underpins their choice of certain lifestyles.

**Nurses need to have access to good quality training, learning and development opportunities that enable them to assess the health needs and develop services that meet the needs of the most disadvantaged in society. Promoting health and preventing ill health is everyone's business and nurses need to have adequate preparation in pre-registration courses and continuing access to specialist post registration opportunities.**

**The RCN calls for obstacles of access and release from work to be recognised, addressed and removed and for greater emphasis on the prevention of ill health in all nursing preparation programmes.**

### **3. Quality**

The central importance of the quality agenda as a helping force for the future of nursing and midwifery and an investment in nurses' ability to lead for quality, standards and metrics is a key consideration when planning for workforce development programmes.

Recent NHS policy has placed care quality as a central organising principle of the NHS in England. Lord Darzi's NHS Next Stage Review report *High Quality care for all* (Department of Health 2008)<sup>2</sup> has stated that quality is of equal importance to access, volume and cost of health care. It is quite clear that the government is serious when it comes to ensuring that the quality of care remains a high priority in all NHS Trusts and it will be important to them in terms of their performance rating, reputation, contestability and credibility with patients and the public.

Nursing is key to the quality agenda as it has demonstrated how it impacts on standards of care quality. The Chief Nursing Officer for England, Dame Christine Beasley has recently published guidelines that outline the strands of nursing that can be drawn together to ensure high-quality nursing care. This is clearly a centrally important agenda for nurses and nursing to grasp that will enable nurses to be fit for the future.

We consider that the technological revolution can both help and hinder the progress of the nursing role and the efficiency with which patient care is delivered. There are real opportunities for nurses when they use tools such as the electronic patient record and technology generally that will enable them to horizon-scan and plan their services more effectively for the future. However, nurses need to have a better understanding of their responsibilities regarding the use of information and IT in clinical practice and the skills they need to develop in managing that information in the delivery of patient care. The risk of loss of patient contact is a concern as the nurse/patient relationship is a unique relationship that is dependent on direct contact.

**The RCN calls for investment in nurses training and development to ensure they are confident in their use of the new technology available to enhance quality patient care. The realisation of this will only be achieved if the IT infrastructure is sufficient and nurses have access to IT at work.**

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<sup>2</sup> Department of Health (2008) *High Quality care for all*, London: DH

#### **4. Workforce**

The RCN calls for an urgent review of the ward sister role (and equivalent in primary/community settings) and a commitment to prepare all ward sisters adequately in non-clinical skills development as a pre-requisite to taking up their role. The RCN considers that this investment should focus on leadership and management training that is transferable across acute and primary care sectors.

**The RCN calls for ongoing support mechanisms for nurses that help them to work effectively across boundaries, professions, teams, organisations and cultures and help foster strong working relationships.**

Over recent years we have seen a lack of investment in a wide range of educational opportunities, continuing professional development, poor and patchy investment in developing leaders across the NHS, skill development for new roles and ways of working, and inadequate investment in the preparation of nurses for the challenges of the 21<sup>st</sup> century and beyond. The RCN has recognised both opportunities as well as obstacles to improvement of services as the NHS 'market' becomes available to non-traditional health care providers in a contestable field. Unless these new organisations are charged with ensuring the ongoing learning, training and development of their staff we could see further erosion of the skilled workforce.

**The RCN asks for all new health care provider organisations to have a well-developed continuing professional development plan for nurses as part of their business submission.**

The emergence of new provider organisations is a potential block to the sharing of good practice amongst nurses as the potential for competition and contestability emerge. Whilst we recognise that there are possible opportunities for nurses in new health care organisations to develop innovative services, there is likely to be less willingness to share learning from best practice across a sector that has a mixed economy.

**The nursing population – an ageing workforce, insufficient numbers and shortages, poor workforce planning all indicate a hindering force for the future. The RCN calls for better workforce planning, taking into account the need for succession planning and the anticipated changes in demand from the increasingly ageing population, chronic illness and co-morbidities.**

The general population of England (and the UK) is ageing. Up until 2006, the population aged over 65 grew by 31 per cent and at that time, the largest growth in the population was at ages 85 and over. There have been no signs of this increase diminishing since then, which raises issues of both capacity and the necessary knowledge and skill base of nurses to be able to rise to this challenge. As we live longer our demands on the NHS will change and we are

likely to continue to increase our demand for services across health and social care. This increase is most likely to have an impact on the demand for care of people with chronic conditions and co-morbidities.

Good workforce planning is crucial for the future of services that meet this growing health need and recognising and addressing the issues of recruitment and retention of staff. The available number of qualified nurses is reducing year on year and the rise in the number health care assistants and associate practitioners is likely to be a workforce pattern for the future. We are likely to see a career structure that demonstrates a number of assistants working as part of the multidisciplinary teams. The shape of the nursing profession will have to change as a steady, stable and possibly smaller supply of graduate nurses provides leadership and supervision in nursing care delivery.

**The RCN calls for a recognition of the importance of and investment in providing responsive training and development opportunities that allow nurses to be confident in this shifting arena of health care delivery and take on the leadership of increasingly multidisciplinary skill mix teams.**

## **5. Culture, Diversity, Equality and Human Rights**

Over the last 30 years, there has been a significant growth in cultural diversity in Britain. Changing patterns of migration and immigration as well as population shifts into the south and others have meant that nursing and midwifery have had to respond to a series of practical challenges and changes in this area.

Since 2000, there has been a growing awareness, particularly within the public sector about the nature of institutionalised discrimination. This has generated three public sector equality duties (disability, gender and race) which have placed a proactive responsibility to eliminate unlawful discrimination, promote good relations and equality of opportunity on public sector organisations and by extension those organised commissioned and/or procured to deliver services on their behalf.

In July 2009, the Equality and Human Rights Commission published their inquiry into human rights.

The burgeoning human rights agenda with its antecedents in the values-based language of 'dignity, respect and fairness' poses some significant challenges to nursing and midwifery. The inquiry report included a number of findings and recommendations which included the following:

- where public service providers had adopted a human rights approach to service delivery, they reported improved services and better and more coherent delivery procedures and increased staff morale

- sector specific training on the application of human rights was effective in motivating staff and improving service delivery.

Despite there being an established legal framework around diversity, equality and human rights issues and demographic changes that have necessitated the production of specific guidance. It must also be noted that the NMC code of conduct contains a number of reference to respecting equality and diversity. However, there is a distinct paucity of provision in terms of consistent training and development.

**The RCN calls for urgent action on the part of nurse educators to develop and embed distinct components on both pre- and post-registration education as well as continuing professional development that enables nurses and midwives to understand and implement equality, diversity and human rights into their practice.**

## **6. Patients, the public, nursing and nurses**

The media's portrayal of nurses is not always a positive caring image, as we experienced in slogans such as 'too posh to wash'. It's potential to influence public perception could be viewed as a potential hindering factor. Added to this, times have changed and so both the public and media understanding of nurses and the role of the nurse may not be totally accurate. Gone are the days when nurses' uniform was an uncomfortable dress, cinched in waist, pretty and frilly hat, clear tights and sensible shoes; when the public thought of nurses first and foremost as young and female. The RCN uses every opportunity to highlight the vital role that nurses play in the provision of high-quality care, highlighting where there are situations that make it a real challenge for nurses to meet their quality objectives and supporting its members in their representation roles when influencing and negotiating for improved conditions of staff.

**The RCN calls for action to promote the image of nurses and to portray their role in a positive manner, that their role is described in an honest and factual way so that the public have a better understanding and clearer expectations of nurses.**

All organisations are now required to set up systems whereby they can capture the views of patients and service users of the health service. This feedback is vital for the continuing improvement of services as well as an opportunity for patients to have a say in how services will be delivered in the future. The RCN has set a standard with its annual member survey (findings discussed in the workforce paper) which helps it to develop the information necessary to support members, nurses and nursing to get their voice heard and to become engaged in the debate about shaping the future of the NHS and their vision for the future.

## **We need an organisational culture that enables nurses and nursing to flourish**

Too often we hear that there is insufficient recognition and acknowledgement of the value and impact of nursing on high quality patient care. An enabling culture is one that is inclusive of all those individuals, groups, teams, staff, patients, service users and anyone else who comes into contact with the organisation that values and listens, evaluates and changes and promotes a positive place in which to work.

Organisations and workplaces are complex and there may be accepted ways of working in an established team. However, in an enabling culture there are opportunities for nurses to influence for change, where they can review the existing organisational culture, create a vision for the future and work with colleagues to ensure that staff are valued, roles and responsibilities are clear, people are able to make decisions, there is a skilled workforce and nurse leadership is strong.

The RCN has gathered evidence from across organisations and senior nurses in the NHS in England that suggests that an enabling culture is not the norm across NHS organisations. In a recently published report following research into the role of the ward sister (*Breaking down barriers, driving up standards RCN 2009*)<sup>3</sup> there is evidence to suggest that some of these qualities and behaviours are not in place. The responsibility for enabling a change in culture is shared across the organisation from a senior executive level through to those delivering patient care and those who use NHS services. It is a shared responsibility of all who work in an organisation; requiring strong leadership at the senior executive level of the trust, and investment in the training, development and preparation of those taking on leadership and management roles at the clinical interface. Crucially, organisational structures can support nurses through lines of reporting and accountability from the bedside to the boardroom. Many nurses are in line management structures where they do not report to a nurse and the RCN believes that this may be detrimental to the patient clinical experience.

**The RCN calls for greater investment in organisational development training and development opportunities (non-clinical skills development) for nurses that equip them with the skills and knowledge to challenge existing disabling cultures and to promote those that enable positive ways of working.**

## **7. Nursing in a changing society**

There are many challenges and opportunities for nurses at all levels in the health and social care system. These range from educational developments;

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<sup>3</sup> Royal College of Nursing (2009) *Breaking down barriers, driving up standards*, London:RCN

changes to the organisation of care and traditional ways of working in the delivery of care; how teams are constructed; a further shift towards an increase in the support workforce and skill mix teams; changing expectations to whole scale system re-organisation; new technology; and an increasingly knowledgeable public.

Just as nurses are experiencing change, so is the expectation of the public of the NHS changing. Patients' demands on the NHS have and continue to change both in their demands for the newest and most up to date treatment as well as access to new medication and technology, but also how and where they access services. When using the NHS, the public expects to receive high-quality nursing care, to be treated with dignity and respect, to be provided with adequate nutrition and to receive their care in an environment conducive to healthy recovery. The younger generation has different expectations of the health service from the older age group who are more likely to use health services in a more traditional way. The younger generation want easily accessible 24-hour services, advice and treatment that they can access whether they are at work or whether they are at home. They do not generally mind who provides this information, be it nurses, doctors, pharmacists or other health care practitioners, but they do expect access to high-quality information.

**The RCN views nurses as key information and knowledge workers, who give the public accurate and high-quality, evidence based health information, and as professionals who make decisions and solve problems based on sound knowledge information.**

**The RCN calls for improved eHealth systems and processes to enable nurses to carry out this key function now and into the future.**

**The RCN calls for 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 drugs, leadership of services, and 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 really fit for the future.

## **8. World class commissioning (WCC) as a lever for re-designing services**

WCC together with Transforming Community Services will continue to have an impact on the way that services are delivered in the future. The Government report *NHS Next Stage Review: our vision for primary and*

*community care*<sup>4</sup>, made a commitment to creating modern and responsive community health services of consistently high standards. Nurses, at the forefront of service delivery and with direct contact with patients and the public are in a prime position to understand what it is that patients want of their community services; where and by whom they want them to be delivered. If nurses are able to compliment this information with quality data, they will be in a strong position to influence the development of and the commissioning of nurse led, patient focused services that meet identified health need. (Policy levers and commissioning are documented in detail in the attached RCN paper on the socioeconomic case for nursing)

**The RCN calls for a commitment of investment in skilling up all nurses so that they are better able to influence the commissioning of high quality services. In particular an assurance that senior nurse executives will have a place on all NHS Trust boards, both in the acute sector and in PCTs.**

**We also call for an assurance that nurse leadership in the community sector will receive the recognition and commitment for funding of training and role preparation that it requires.**

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<sup>4</sup>Department of Health (2008) NHS Next Stage Review: our vision for primary and community care. London:DH

## 9. Recommendations

**Nursing leadership** - investing in the preparation of nurses for taking on leadership roles in a variety of health care settings that drive up standards and enhance patient care within and across organisations, specifically:

- an urgent review into the ward sister role together with a commitment to investing in their training and development
- a review of the nursing team leadership role in community and primary care settings and an assurance of investment in their training and development as a pre-requisite to taking up post
- investment in nurses' team leadership skills to equip them to effectively lead and manage skill mix in multi-disciplinary teams, in both primary and secondary care settings.

**Quality** – investing in the nursing workforce as a key role for nurses and nursing in driving high quality services (please see attached RCN paper on quality and innovation for more detail), specifically:

- invest in nurses' ability to lead for quality, standards and metrics when planning for workforce development programmes
- commitment to invest in nurses' training and development to ensure they are confident in their use of the new technology available to enhance quality patient care
- that commissioners ensure that there are mechanisms in place that enable nurses to share evidence based good practice across all provider organisations that enhances high quality patient care.

**Workforce** – there is an urgent need to review a range of issues concerning the existing nursing workforce (please see attached RCN paper on workforce and leadership for further detail), specifically:

- commitment to prepare all ward sisters (and their equivalent in primary/community settings) adequately in non-clinical skills development as a pre-requisite to taking up their role. The RCN considers that this investment should focus on leadership and management training that is transferrable across the acute and primary care sectors
- implementation of appropriate ongoing support mechanisms for nurses that help them to work effectively across boundaries, professions,

teams, organisations and cultures and help foster strong working relationships

- a requisite that all new health care providers should have a well-developed CPD plan for nurses as part of their business submission
- better workforce planning, taking into account the need for succession planning and the anticipated changes in demand from the increasingly ageing population, chronic illness and co-morbidities
- recognising the importance of and investing in providing responsive training that allows nurses to be confident in the shifting arena of health care delivery and take on the leadership of increasingly multi-disciplinary teams.

### **Culture, diversity, equality and human rights**

- Urgent action is required on the part of nurse educators to develop and embed distinct components on both pre- and post-registration.
- Education as well as continuing professional education that enables nurses and midwives to understand and implement equality, diversity and human rights into their practice.

### **Patients, the public, nurses and nursing**

- The RCN calls for action to promote the image of nurses and to portray their role in a positive manner, that their role is described in an honest and factual way so that the public have a better understanding and clearer expectations of nurses.
- Greater investment in organisational development training and development opportunities (non-clinical skills development) for nurses that equip them with the skills and knowledge to challenge existing disempowering cultures and to promote those that enable positive ways of working.

**Nursing in a changing society** - The RCN views nurses as key information and knowledge workers, who give the public accurate and high quality, evidence based health information, and as professionals who make decisions and solve problems based on sound knowledge information.

- The RCN calls for improved eHealth systems and processes to enable nurses to carry out this key function now and into the future.
- Greater investment in developing role clarity for new and emerging nursing roles.

- Commitment to investment in skilling up all nurses so that they are better able to influence the commissioning of high quality services.
- An assurance that senior nurse executives will have a place on all NHS Trust boards, both in the acute sector and in PCTs.
- An assurance that nurse leadership in the community sector will receive the recognition and commitment for funding of training and role preparation that it requires.

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Royal College of Nursing, July 2009

# Workforce and leadership

Royal College of Nursing submission to the Prime  
Minister's Commission on Nursing and Midwifery

**Note:** The Royal College of Nursing welcomes the opportunity to submit papers for the Prime Minister's Commission on the future of Nursing and Midwifery. Please note that the attached paper is one of five that the RCN has provided to the Commission to enable it to take forward its important work. Readers should be aware that there are a series of key themes and recommendations that run across all five documents submitted by the RCN and no individual paper should be considered in isolation. All the documents describe the role of the nurse now and in the future as well as commenting on the value of nursing, both qualitatively and economically, and its relationship with and influence upon wider society. When themes are covered in more than one paper we have included a cross reference wherever possible.

## Workforce and leadership

In order to consider how well placed front-line nursing staff are to maximise opportunities to take a central role in the design and delivery of 21<sup>st</sup> century services, it is essential to consider labour market issues, i.e. supply and demand; as well as competence and capacity.

It is the view of the Royal College of Nursing 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 wellbeing, and particularly, to develop primary and community care services.

The RCN has continued to highlight the crucial role of skilled nurses who can provide both leadership and supervision in nursing care delivery. Nursing leadership is not just about those in executive positions; it is about the leadership that exists within and across an organisation and a culture that enables nursing leadership to flourish and that improves patient care. Leadership preparation should be introduced across the nursing profession at pre registration level and at qualification as all will need to adopt leadership strategies.

### **1) The labour market – do we have enough nurses? A potential block**

#### **a) Department of health vacancies**

While there is no 'official' shortage according to the Department of Health (DH) at the moment this is partly due to the way their 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.

**We need agreement on the definition of a nursing staff vacancy to ensure more accurate assessment of the state of the labour market.**

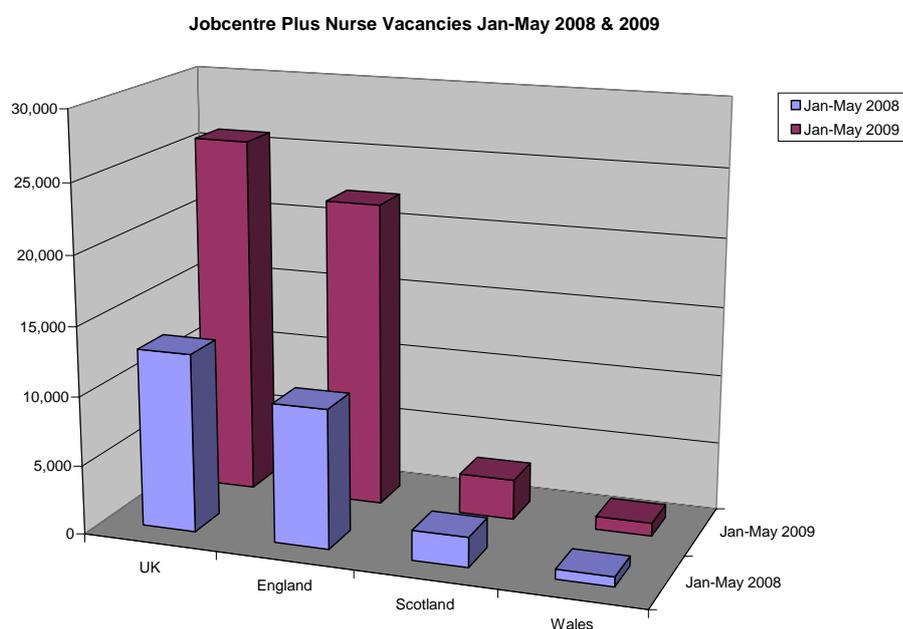
#### **b) Evidence of shortages**

Jobcentre Plus data shows that nursing vacancies have shot up since last year. More than 4,000 extra vacancies were advertised in the UK in April, compared with the figure a year ago. The data revealed a rise in adverts 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.

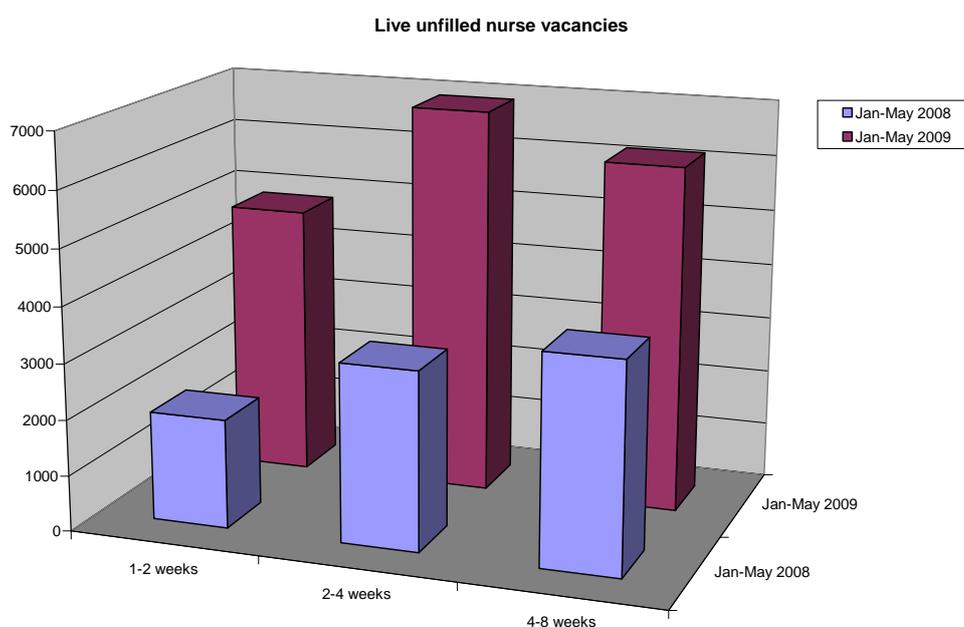
The following graph<sup>1</sup> shows the difference in notified nurse vacancies, comparing the first five months of 2008 with the same period this year. There

<sup>1</sup> <https://www.nomisweb.co.uk/>

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.



The same trend is 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.



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 20 years.

**Acknowledgement that there is an emerging potential mismatch between supply and demand is an important first step to dealing with the issue of shortage.**

#### **c) Education commissions**

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. Reductions in commissioning in 2005/06 will start to play through to corresponding training output declines in 2009. 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.**

#### **d) The global picture**

The American Health Care Association's most recent estimates from July 2008 show 116,000 open hospital nursing positions and more than 19,000 vacancies in long-term care settings. The economic downturn has helped some hospitals as many nurses increase their hours and postpone retirement, but experts say that any lull in shortages is temporary.

A March 2008 report by Dr. Peter Buerhaus of Vanderbilt University Medical Center and colleagues, predicted that national nursing shortages could balloon to 500,000 by 2025. Predictions from the U.S. Department of Health and Human Services are more dire – it anticipates a shortage of 1 million nurses by 2020.

The UK has in recent years been able to benefit from the global mobility of the nursing sector and tap into the worldwide nursing talent pool to fill its vacancies, however, demand exceeds supply across the world and the UK is in competition with many other countries for the global pool of available nurses. The recent restrictions on nurses entering the UK has seen an increase in the number of non-EU nurses going to other developed countries in shortage, such as the US, Canada and Australia.

Nurses from countries that have traditionally had good links with the UK are now migrating to the US and Canada and the RCN is concerned that when the UK wants to start recruiting nurses from overseas again, those links will have been lost. Some countries that habitually trained a sizeable proportion of their nurses for export to the UK, such as the Philippines, are now sending their nurses elsewhere.

Many UK nurses are also leaving the UK to go and work abroad to destinations such as Canada, Australia, the Middle East and the US. The following table provides details of the number of verification checks made by regulators outside the UK for nurses and midwives on the NMC register by country and we can see a steady increase over the past four years.

Country	2005	2006	2007	2008
Australia	3,296	3,047	4,764	5,581
USA	1,729	1,338	1,613	1,701
New Zealand	1,097	1,423	1,336	1,237
Eire	847	1,009	999	1,011
Canada	461	404	739	898
Spain	124	132	142	164
United Arab Emirates	28	18	42	66
France	74	87	60	62
Other	375	341	384	458
<b>Total</b>	<b>8,031</b>	<b>7,799</b>	<b>10,079</b>	<b>11,178</b>

However, global mobility can provide opportunities as well as challenges. The RCN believes it is important to provide opportunities for nursing staff and other health workers to spend time working or volunteering in another country before returning to the UK and for there to be recognition of the contribution that overseas experience can make to developing flexibility, innovative approaches and team leadership.

### **e) Community nursing and primary care and the independent sector**

Much of the policy from the Department of Health in recent years has demanded an increase in the community nursing and primary care workforce. According to the RCN's Employment Survey, one in three community nurses are now over 50 years old and more than a fifth of practice nurses are over 55, which adds up to around 200,000 nurses who are due to retire over the next decade. This represents almost 50 per cent of the nursing population and this will leave a massive skills shortfall in the workforce. This is a worrying prospect at a time when the size of the UK's elderly population looks set to continue to increase over the coming years, meaning the demand for specialist nurses and community based nurses will continue to grow with it.

The community nursing sector is already under resourced to fulfil existing policy drivers (Care closer to home, Next stage review, Transforming Community services etc.). 'Growing' the primary care nursing workforce is not just a simple matter of recruiting direct from the acute sector or direct from UK

training. The skills base required to work in the community is different to working in a hospital.

**There will have to be more investment in specialist bridging training for hospital based nurses and this will require a period of increased investment in the number of nurses overall, to maintain good quality of care while the workforce is being developed to deliver the demands of the service.**

Currently, the primary care nursing workforce is 'grown' principally in the NHS, but this may not be the case in the future if the policy push for pluralist delivery of primary care by the private sector and social enterprise continues. Nurses and nurse leaders will need to be grown within those organisations too. Experience suggests this may be a challenge as the current example of GP practice nurses suggests. GPs are nominally responsible for the competence, development and professional leadership of the nurses they employ. However, in reality, PCTs and SHAs struggle to support training and provide professional leadership for this group of staff. There are issues about accessibility and many practice nurses end up attending in their own time or not at all. As nurses are employed in increasingly diverse employment settings by providers unfamiliar with professional support and development for nurses, the provision of and access to continuing professional development (CPD) is likely to become a bigger issue.

**Workforce planning needs to include consideration of the whole of the future nursing workforce; in and outside the NHS.**

**The RCN believes there should be enablers and requirements into the system which would require all employers to sign up to a level of support, supervision, provision of professional leadership.**

## **2) The working environment in the NHS; block or enabler?**

The RCN has carried out 22 employment surveys of members over 26 years. Analysis has demonstrated that RCN membership is broadly representative of the nursing staff population of nursing staff more generally. Standardised questions are used so changes over time can be explored. The last published RCN Employment Survey<sup>2</sup> was carried out in 2007.

In 2007 findings were as follows:

- 59 per cent said their workload too heavy
- 58 per cent worked more than contracted hours
- 26 per cent had a second job
- 87 per cent said they felt poorly paid compared with other professions
- 55 per cent felt they were too busy to give the kind of care they'd like to

The proportion of nurses working excess hours has remained unchanged for the last 10 years.

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<sup>2</sup> Ball J & Pike G (2007) [Holding On: Nurses' Employment and Morale in 2007](#)

Preliminary findings from the 2009 survey which will be published in September show that despite an overall improvement in morale and motivation since 2007, views of workload have not improved; 52 per cent that they are under too much pressure. 54 per cent of all nurses say they are too busy to provide the level of care they would like. Despite the numbers of new nurses in the system, staffing ratios in the acute sector remain similar to the time when the shortage was at its worst, indicating how demand has increased.

The most recent NHS staff attitude survey for England 2008<sup>3</sup> shows 90 per cent of staff feel they make a difference to patients and around 66 per cent feel able to give the level of care to which they aspire. The findings relate to all staff groups but there are important similarities between findings of the NHS staff survey and the RCN's employment survey; 47 per cent of respondents to the NHS survey feel there are not enough staff to allow them to do their job properly for example. Two thirds of staff work longer than their contracted hours. Those staff suffering workplace stress fell from 33 per cent in 2007 to 28 per cent in 2008 but levels of bullying, harassment and violence remain at worrying levels.

A survey of RCN safety representatives<sup>4</sup> published in 2008 told us that the issue that safety representatives are called upon to deal with most frequently is work related stress.

Research shows evidence of a relationship between the quality of patient care and the working environment of staff. The RCN has developed a framework illustrating the dimensions of effective workplace culture<sup>5</sup>. The International Council of Nursing has produced guidance on Positive Practice Environments<sup>6</sup>.

The RCN is calling on the government to:

- **commit to tackling physical violence and verbal abuse towards nurses and other health care workers by prosecuting their attackers and investing in measures to reduce the risks of violence to all, including lone 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 health care staff**
- **legislate for a preventative approach to the protection of nurses and other health care workers from potentially life threatening needle stick and sharps injuries including the provision of safer needle devices and systems**

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<sup>3</sup> [National survey of NHS staff conducted in 2008](#)

<sup>4</sup> [www.rcn.org.uk/data/assets/pdf\\_file/0020/195401/Survey\\_of\\_RCN\\_Safety\\_Reps\\_2008\\_-\\_final\\_report.pdf](http://www.rcn.org.uk/data/assets/pdf_file/0020/195401/Survey_of_RCN_Safety_Reps_2008_-_final_report.pdf)

<sup>5</sup> Manley et al (2007) *Effective Workplace Culture: concept analysis*. In, RCN Workplace Resources for Practice Development, RCN London, pp 6.10

<sup>6</sup> [www.icn.ch/indkit2007.pdf](http://www.icn.ch/indkit2007.pdf)

- **protect the health and safety of nurses, patients and other health care 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 an effective way of managing staff relations.**

### **3) Learning and development; essential enabler but blocked in reality**

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

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 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, as 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.

**It is important that nurses are fully engaged in the debate about the competences required for world class commissioning, and that competence in continuous improvement of the quality of care, based on knowledge and understanding of the patient experience, is seen as essential in good procurement as financial skill. Achieving this engagement requires nurses' own efforts to get to grips with commissioning but also recognition of the added value of the nursing contribution at the commissioning table.**

Just as the workforce is changing so are patients. Nursing staff need to work differently with empowered patients who are experts in their condition. Education is required to help nurses, HCAs and others recognise the difference between doing for others and helping others do for themselves.

However, the preliminary findings from the RCN's 2009 Employment Survey show 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 (5.3 days) have undertaken less CPD than other groups of NHS nurse.

- Three in ten nurses (29 per cent) think the amount of CPD they have undertaken in the last year has increased and 22 per cent think it has decreased.
- Just over six in ten nurses (61 per cent) 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 per cent).
- 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 per cent in 2009 compared to 63 per cent in 2007) and more nurses working in independent care homes have also received infection control training (81 per cent compared to 67 per cent in 2007).
- Views of access to training opportunities are more slightly more positive in 2009 than was the case in 2007, but remain lower than was recorded in 2005.

By comparison the NHS staff attitude survey for England 2008 reports 40 per cent of staff reporting they have good development opportunities, 64 per cent had had an appraisal in 2008 and 55 per cent had a personal development plan. Implementation of the knowledge and skills framework 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.

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. The RCN believes 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 health care assistant should have protected training time as part of their continual professional development and all newly registered staff should be provided with preceptorship.**

The RCN has published competences for nursing based on the KSF dimensions.<sup>7</sup>

#### **4) Skill mix**

**The RCN believes that there should be regular nurse staffing reviews in all health care settings to ensure appropriate staffing levels that meet patient needs, ensure patient safety and quality care.**

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<sup>7</sup> RCN (2009) Integrated core competence and career framework for registered nurses. RCN Competences RCN London

In 2006, the RCN produced policy guidance on skill mix ratios in acute settings<sup>8</sup>. Skill mix ratios for general NHS wards had averaged between 62 per cent to 68 per cent registered nurses and 38 per cent to 32 per cent health care assistants (HCAs) over the past five years while the severity of patient illness and bed occupancy had increased. Ratios improved marginally in 2007 but the preliminary findings of the RCN's 2009 Employment survey show that ratios have reverted to 2005 levels.

The RCN recommends that a skill mix ratio of 65 per cent registered nurses to 35 per cent HCAs is the benchmark for the general wards unless a thorough review of ward staffing levels has taken place, in accordance with RCN principles set out in the 2006 guidance.

**The RCN believes that nursing staff grades should not be reduced and skill mix should not be altered solely on financial grounds. There is emerging evidence that some NHS employers are 'down banding' to offset the costs of Agenda for Change. The RCN will continue to monitor the situation.**

As numbers of HCAs and assistant practitioners (APs) continue to grow **the RCN believes that regulation of this staff group is key to accountability, protecting the public and patient safety.**

#### **5) To work differently there is a need for investment – building nursing leadership competence and capacity**

The RCN has highlighted the need for continuing and increased investment in nursing leadership for many years, recognising the importance of building the capability of nurses to improve patient care as well as to champion nursing and patient care quality at board level. As demography of the population changes and we see a growing number of people living for longer the associated demands for health care also change. These demands will be better met as nurses take on leadership roles that enable change and are supported by employers who develop programmes to enable nurses to move into management roles in a culture that nurtures leaders. Quality is central to improving and modernising the NHS and we know that effective nursing leadership can make a real difference to the quality of health and social care. The ultimate benefit is realised by patients and the public whose experience will be one of high quality care in an environment where safety, security and health are fundamental and where **nurse leaders make a positive difference to the experience of patient care.**

**The RCN calls for greater investment in leadership development that challenges and changes culture**

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[http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0008/20411/setting\\_appropriate\\_ward\\_nurse\\_staffing\\_levels\\_in\\_nhs\\_acut.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0008/20411/setting_appropriate_ward_nurse_staffing_levels_in_nhs_acut.pdf)

By this, we include organisational culture, the environment in which care is provided as well as the direct provision of care. 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 (Hay Report 2006). Research by the RCN, *Dignity: at the heart of everything we do* (Royal College of Nursing, Dignity Campaign [www.rcn.org.uk/newsevents/campaigns/dignity](http://www.rcn.org.uk/newsevents/campaigns/dignity)) has demonstrated how important it is to nurses that they are able to take on their leadership roles in order to ensure that there is sufficient time to devote to the dignity of patients. Where nurses have sufficient time to provide high-quality, safe, patient centred care we know of the positive impact on their own well being and staff morale more generally. We need **strong nurse leadership that challenges the status quo and identifies areas of change and how change can be achieved**. This requires vision that can be articulated and an ability to engage others in the realisation of the vision. It also includes an ability to influence others in the achievement of the vision and to work with others to explore options for a changing culture that is sustainable and enables the flourishing of innovation.

### **RCN calls for greater focus and investment in developing nurses as leaders and managers of quality patient centred care of multi-disciplinary teams.**

We recognise that changes in the way services are, and will be delivered in the future require **nurse leaders who are skilled at working across organisational boundaries and creating alliances** with a range of stakeholders. This learning and development should take place within multidisciplinary management and leadership programmes that aim to enable nurse leaders/managers to gain a wider perspective of the NHS and care sector. In addition, pre-registration interdisciplinary leadership learning should be standard and should be woven through the career pathways of nurses. The focus would be on **leading teams and team development** as the vehicle for getting things done. The new roles and responsibilities of nurses, HCAs and other health care professionals are likely to lead to confusion regarding accountability and who is responsible for what. Investing in team building will help clarify roles within the 'modern workforce' and reduce the risk to patients and staff.

### **RCN calls for an increased focus on and investment in the development of nurse leaders who enable patients and service users to be empowered**

The changes in the way people live their lives and the increase in the age profile of the population, together with an economic downturn requires nurse leaders who can sustain the changes required for this to happen. They will **take the lead for working with and implementing national strategies for health improvement**, such as the 'expert patient', encourage self care and work closely with individuals and communities to promote health and well being. Increasingly, nurses are working in skill mix teams and their leadership skills are required to ensure that all members of the team are skilled at

providing high quality care as well as develop the skills that enable and empower people to do things for themselves. Whilst there has been much improvement for patients in terms of treatment, the health inequalities gap remains wide and there has been poor investment in areas where we need cultural change in order to transform the health and life chances of the population. Nurses can develop the leadership skills that help to identify health need, seek out those who do not readily use services and work with others to influence commissioners to purchase and provide innovative and cutting edge services.

### **The RCN calls for investment in leadership and management development as a pre-requisite to ward sister roles**

The RCN recently published a ward sister report '*Breaking down barriers, driving up standards*' that highlighted the need for better preparation of nurses at ward sister level. The breadth of the ward sister role encompasses both leadership and management, clinical practice, education and teaching. We know that patient care and health improve when nurses take on leadership roles, where they continue to work in clinical areas and where they take on supervisory roles. The RCN Clinical Leadership Programme (CLP) provides a framework to develop leadership and management capabilities and is one of the longest running leadership programmes for ward sisters. Evidence from the programme evaluations highlights the positive impact on developing confident and competent ward leaders who can make a positive difference to the experience of patients care.

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 needs access to **tailored leadership and management development programmes, peer review, mentorship and shadowing opportunities**. The RCN calls for these programmes to be made available to all those taking on these posts. This agreed commitment should be made available both prior to and on appointment.

The RCN also believes that similar investment in clinical management careers should include those nurses in similar roles in community settings, who are faced with management and leadership challenges that are different but equally demanding. In the community, where we have seen a rapid increase in skill mix, together with dilution of trained nurses, we consider that there is an **urgent need to review and invest in skilled nurse leaders**. If commissioning is the essential vehicle and lever for redesigning services, nurse leaders will be influential in ensuring this happens.

### **The RCN calls for investment in nursing leadership around eHealth, the e-agenda, telehealth and telecare that enables nurses to take the lead for innovative communication methods and new services**

The technological revolution has led to major changes in the way that some groups of the population access information about their health and health

care. In many respects the NHS has risen to the challenge of increasing the availability of health information via the web as well as providing a 24 hour web and telephone information service. However, we also recognise that there are wide variations in access to this technological information that has led to a recognition that the majority of people currently using the NHS are over 65.

The term eHealth refers to the use of information and communication technology (ICT) in health care. There are few areas of nursing that will not be touched and it will become increasingly difficult to practice without appropriate information skills and a higher level knowledge of information governance and information management. eHealth technologies will evolve and nursing will need to evolve with them. Nurses at all levels will need to be:

- flexible - to adapt to emerging technologies
- creative - to exploit existing and future potential
- confident - to help the public engage with eHealth.

Alongside the technological revolution, nurses have seen patients become more knowledgeable about their health, their illness, methods of treatment and recovery and frequently find that patients are far better informed than in the past. **This is a revolution that requires adequate investment in a changing world of health information.**

**RCN calls for investment in nursing leadership in both commissioning and providing services in the changing world of health and social care.**

As previously stated in this paper, it is essential that **nurses take a leading role in commissioning and providing services** and in order to be successful in these roles they will need to develop a range of influential 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. For nurses to be able to take on these influential roles, they would need to develop the skills that enable organisations to become excellent World Class Commissioners and outstanding health providers. 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, and nurses at this level are central to ensuring that quality and clinical effectiveness are key to success. In addition, **the ability to articulate the unique contribution that nurses and nursing bring to the development of innovative person centred services** is crucial.

**RCN calls for development of senior and executive nurses to confidently influence, be influential and political**

Caring for patients is key to the business of health care. This is crucial at the highest levels of each health organisation. The excellent work carried out by the Burdett Trust is very useful in this regard. The Burdett Trust has worked for the past five years on the analysis of the leadership skills needed by

nurses as they advance their career pathway<sup>9</sup>. This report recognised **the need to skill up nurses so that they can bring their clinical nursing leadership roles to the board room.**

In order to build the political and communication skills of its nurse members, the RCN created an innovative programme, the RCN Political Leadership Programme (PLP). The primary aim of this leadership programme was to enable the participants to influence health and social care policy by developing their skills to increase their involvement in media work, campaigning and lobbying. Evaluations from the programme have demonstrated that it has been very successful at developing the policy and political acumen of nurses with evidence of both their personal, professional development and their impact politically. The success of the leadership initiative has been such that it has also been commissioned and delivered to a range of senior and executive nurses.

The RCN has published a position statement on the need for an executive nurse director on the board of every PCT in England. There is an anomaly where such a position exists as of right at foundation trust boards (providers) but does not exist as of right in PCTs whether they are providing or commissioning<sup>10</sup>. The RCN policy position is that every Primary Care Trust in England should have an executive director of nursing at board level. Every nurse executive director should be currently registered to practice as a nurse with the Nursing and Midwifery Council, hold full voting rights and be in full time employment by the PCT. This will ensure that **the voice of nursing is properly represented within the governance of the NHS.**

**The RCN calls for a clear pathway for nurses to develop the skills throughout their career from front line services to Board level influence. The RCN calls for** additional resources to be made available to ensure that nurses can develop their skills of engagement with staff and other board members and take up these leadership roles with confidence. Drawing on their professional experience would enable them to be more influential on a range of agendas, national and local and in arenas where decisions can be made based on sound advice. In addition, nurses need the confidence and competence to contribute to regional development agencies and to help shape the health agenda, where nurse representation is recognised as part of the key stakeholder group rather than just the deliverers of change. However, leadership development for executive nurses is not enough on its own and we would see this as being supported by the provision of a range of ongoing support mechanisms, such as access to active learning sets, mentorship and coaching.

Finally, the RCN calls for a **commitment to ensure that all leadership initiatives and opportunities are sustainable.** Sustainability can be

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<sup>9</sup> An exploratory study of the clinical content of NHS Trust board meetings in an attempt to identify good practice" (2006, The Burdett Trust for Nursing); Who Cares Wins: leadership and the business of caring (2006 The Burdett Trust for Nursing); The Nurse Executives' Handbook leading the business of caring from ward to Board" (2009 The Burdett Trust for Nursing and the Kings Fund)

<sup>10</sup> RCN Policy Position Executive Director of Nursing (2009 Royal College of Nursing)

described as when new ways of working and improved outcomes become the norm. To do this, there needs to be a particular focus on the systems and people surrounding the innovation which need transforming to support it, so that the innovation has been mainstreamed and integrated into ways of working rather than seen as an 'add on'. (NHS Sustainability guide 2005).

## **7. Recommendations**

**The RCN is calling on the government to:**

- 1. Agree the definition of a nursing staff vacancy to ensure more accurate assessment of the state of the labour market.**
- 2. Acknowledge that there is an emerging potential mismatch between supply and demand as an important first step to dealing with the issue of shortage.**
- 3. 'Join up' workforce planning including input from the devolved administrations and the independent sector.**
- 4. Invest in specialist bridging training for hospital based nurses. This will require a period of increased investment in the number of nurses overall to maintain good quality of care while the workforce is being developed to deliver the demands of the service.**
- 5. Provide a requirement for all health care provider employers to sign up to a level of support, supervision, provision of professional leadership for nursing staff.**
- 6. Commit to tackling physical violence and verbal abuse towards nurses and other health care workers by prosecuting their attackers and investing in measures to reduce the risks of violence to all, including lone workers.**
- 7. 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 health care staff.**
- 8. Legislate for a preventative approach to the protection of nurses and other health care workers from potentially life threatening needle stick and sharps injuries including the provision of safer needle devices and systems.**
- 9. Protect the health and safety of nurses, patients and other health care workers by ending the practice of opting out from the 48-hour working week and ensuring compensatory rest for those who work on-call.**
- 10. Ensure that nurses who raise concerns in the workplace are protected when they speak out.**
- 11. Commit to workplace representation and partnership working as an effective way of managing staff relations.**
- 12. Engage nurses in the debate about the competences required for world class commissioning to ensure that competence in continuous improvement of the quality of care is seen as essential in good procurement as financial skill.**

- 13. Provide protected training time as part of continuous professional development for nursing staff and health care assistants and provide all newly registered staff with preceptorship.**
- 14. Ensure regular nurse staffing reviews in all health care settings to ensure appropriate staffing levels that meet patient needs, ensure patient safety and quality care.**
- 15. The RCN believes that nursing staff grades should not be reduced and skill mix should not be altered solely on financial grounds. There is emerging evidence that some NHS employers are 'down banding' to offset the costs of Agenda for Change. The RCN will continue to monitor the situation.**
- 16. Regulate Health Care Support Workers.**
- 17. Invest in the development of nurse leaders that can make a positive difference to the experience of patient care**
- 18. Provide appropriate support and development for existing nurse leaders, regardless of their position or role.**
- 19. Provide leadership programmes to all those taking on ward sister posts as an essential pre-requisite to taking on this role.**
- 20. Invest and develop strong nursing leadership that challenges the status quo and identifies areas of change and how change can be achieved.**
- 21. Commit to the development of nurse leaders who are skilled at working across organisational boundaries and creating alliances.**
- 22. Greater focus and investment in developing nurses as leaders and managers of quality patient centred care of multi-disciplinary teams.**
- 23. Ensure nurses have access to development opportunities that enable them to confidently lead multi-disciplinary teams and team development**
- 24. Commit to developing nursing leaders who are skilled in taking the lead for working with and implementing national strategies for health improvement.**
- 25. Ensure access to tailored leadership and management development programmes, peer review, mentorship and shadowing opportunities for all ward sisters and senior clinical nurse leaders.**
- 26. Urgently review the role of clinical leaders in community settings.**
- 27. Investment in nursing leadership around eHealth, the e-agenda, telehealth and telecare that enables nurses to take the lead for innovative communication methods and new services.**
- 28. Invest in nursing leadership in both commissioning and providing services in the changing world of health and social care.**
- 29. Development of senior and executive nurses to confidently influence, be influential and political.**
- 30. A commitment to ensure that all leadership initiatives and opportunities are sustainable.**

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# The socioeconomic case for nursing

Royal College of Nursing submission to the Prime Minister's Commission on Nursing and Midwifery

**Note:** *The Royal College of Nursing welcomes the opportunity to submit papers for the Prime Minister's Commission on the future of Nursing and Midwifery. Please note that the attached paper is one of five that the RCN has provided to the Commission to enable it to take forward its important work. Readers should be aware that there are a series of key themes and recommendations that run across all five documents submitted by the RCN and no individual paper should be considered in isolation. All the documents describe the role of the nurse now and in the future as well as commenting on the value of nursing, both qualitatively and economically, and its relationship with and influence upon wider society. When themes are covered in more than one paper we have included a cross reference wherever possible.*

## The socioeconomic case for nursing

### Introduction

The current financial crisis has led to renewed scrutiny of public finances in terms of value for money, effectiveness and quality. In an environment of distrust in public institutions and public officials, leaders of both the main political parties attended RCN Congress 2009 to address nurses directly on their vision for a new engagement with the public based on nursing values of trust and selflessness.

The nursing profession has consistently been rated as one of the most trusted professions. Where does that trust come from? The tangible evidence base is relatively small but growing in importance. For the public, the intangible values such as care, compassion, dignity and relationships remain at least as important as cost. It is through addressing both sets of values that nursing and indeed the NHS can remain a sustainable cause through the next 10 – 15 years.

This paper seeks to address the relative strengths and weaknesses of the social and economic case for nursing. It reviews in brief the tangible and the intangible evidence for a significant role for the nursing profession in the future. The nursing role will need to evolve over time to meet the various systems challenges but should also act to retain significance in the eyes of the public and politicians.

The key areas this paper will seek to address include the following:

- how is nursing contribution shaping and being shaped by current policy drivers internal and external to health and social care?
- what tangible evidence exists around the economic benefit for nursing in the current financial climate?
- what role does culture play in addressing the tension between cost and care?
- where should nursing look to develop and expand its role in society, and in particular within public health?

## Broad policy context and impacts

In broadest terms there have been three key developments in terms of the socioeconomic context which have most directly impacted upon nursing and upon the environment in which care is delivered in England:

1. new incentives for quality within funding reforms
2. separation of provider and commissioner services
3. patient mobility across localities, regions and even national borders.

The above initiatives have been introduced against the reality that increasing demand and limited resources are leading decision makers to consider how best to allocate resources in the most effective manner for social, economic and other policy goals.

As one of the largest sections of the health and social care workforce, nursing warrants attention both at the micro and macro level. Not only is nursing invited to play its part in contributing to and shaping the above agenda, but it is also being asked to innovate and find creative ways of addressing the demanding task at hand – delivering high quality care patient care within limited funds and increasing expectations. The following section provides more detail under each of the above three headings.

### 1. Incentives for quality and funding reforms

There has been longstanding interest in how payment to healthcare organisations and practitioners affects services received in relation to the cost of healthcare<sup>1</sup>.

NHS England has been reimbursing providers for acute care using an activity based case mix payment system called Payment by Results (PbR) since 2003. PbR uses healthcare resource groups (HRGs) as a means of classifying patients' treatment episodes for reimbursement<sup>2</sup>.

Although efforts have been made within PbR to engage clinicians (by which we mean all members of the multidisciplinary team) in the gathering of data, nursing costs are still treated purely as a workforce cost which is aggregated to the unit or department level and allocated on the basis of the amount of patient time spent (for e.g. theatre hours or bed days). Within that 'pooled cost', there is little recognition of nursing effort/inputs, patient dependency, and skill. The detailed focus on classifying activity is predominantly medical procedural costs and diagnosis.

<sup>1</sup> Christensen, J, Leatherman, S and Sutherland, K (2007), Financial incentives, healthcare providers and quality improvements a review of the evidence. London: The Health Foundation

<sup>2</sup> Department of Health (2009) *NHS Costing Manual 2009*. London: DH

Because of the nature of the tariff coupled with an absence of a more complete understanding of nursing costs and their contribution to the overall process of patient care, the RCN believes that nursing workforce numbers and skill mix may be subject to inappropriate cuts as was seen during the 'NHS deficits crisis' of 2006/7<sup>3</sup>.

In the first ever study to align HRGs with patient dependencies and related nursing activity and quality, the RCN recently reported that it found wide variation in the cost of delivering nursing care in hospital settings which appeared to be related to patient dependency. Given that nursing care costs are aggregated under PbR it is not clear what incentives are given to deploy the right nurses with the right skills to meet the patients' assessed needs, nor that they receive the correct level of reimbursement under PbR to make that investment<sup>4</sup>. Failure to include clinicians in creating a culture of gathering patient level information will significantly impact upon any attempt to control costs in a sustainable manner without impacting on the quality of care.

Whilst there is significant interest in efficiency, there has been less focus on the incentives to raise care quality. The RCN 'care crunch' document published in 2008 highlighted that nurses reported that health care systems made it more difficult to deliver high quality care, rather than supporting them<sup>5</sup>. There was concern that clinical issues were squeezed by factors such as restructuring and financial incentives<sup>6</sup>.

The NHS Institute for Innovation and Improvement study by Helen Bevan looked at the balance between cost and quality. The conclusion of this work was that too often in the NHS and other health care systems, cost and quality are seen as trade-offs or alternative priorities. Quality and finance must in practise be equal partners in relation to the delivery of health care. Nurses at every level are a key part in ensuring that ambition is achieved.

For decision makers, the need to reduce the costs may sometimes supersede all other consideration.<sup>7</sup> However nurses and other health professionals can be active and visible champions of both quality and cost controls with both factors being fully integrated into the mainstream of each organisation.

### **The RCN's key recommendations in terms of incentives for quality and funding reforms are as follows:**

- **nurses form an integral part of the team for most episodes of care and therefore should be a key focus for quality indicators and for**

<sup>3</sup> Royal College of Nursing (2007), 'Keep Nurses Working, Keep Patients Safe'. RCN national campaign

<sup>4</sup> Royal College of Nursing Policy Unit (2009) 'PbR and Nursing: Understanding the cost of care', London: RCN.

<sup>5</sup> RCN Policy Unit (2008) Policy Overview (NHS England): *The Care 'Crunch'*, London: RCN.

<sup>6</sup> Dickson, N (2009) *The NHS Beyond the Budget*. London: The King's Fund. Available from [www.kingsfund.org.uk/discuss/the\\_kings\\_fund\\_blog/the\\_nhs\\_beyond\\_the.html](http://www.kingsfund.org.uk/discuss/the_kings_fund_blog/the_nhs_beyond_the.html)

<sup>7</sup> Bevan, H (2009) *Helen Bevan on cost and quality*. London, NHS Institute for Innovation and Improvement. Available at [www.institute.nhs.uk/quality\\_and\\_value/introduction/article\\_19.html](http://www.institute.nhs.uk/quality_and_value/introduction/article_19.html)

**funding reforms. Over recent years nursing teams have re-engineered their roles to assume a higher range of clinical responsibilities, and successfully adapted to use new systems to improve patient care**

- **therefore the nursing contribution to care needs to be explored further in the context of the incentives described above and not simply aggregated as a simple workforce cost**
- **further work on triangulating nursing, patient and service indicators will provide a focus for quality of care and help balance the tensions described above.**

## **2. Separation of provider and commissioner functions**

The NHS Next Stage Review<sup>8</sup> highlighted the need for modernisation within community health services and recommended ‘...removing what are still unwarranted variations in quality of care...’. The review also signalled the separation of the commissioning and provider functions of primary care trusts (PCTs) in order to enable focus on improving both provider and commissioning services. All PCTs are now required to create at least an internal separation of their operational provider services ‘...and agree service level agreements for these, based on the same business and financial rules as applied to all other providers’<sup>9</sup>.

In terms of provision of services, the shift of care closer to the community has brought significant change in the way nurses work and has provided opportunities to try new models of delivery. In reality, innovation has been limited as risks remain high for individuals seeking to set up their own businesses or leave the relative security of NHS terms and conditions.

Government policy has also promoted the greater use of choice and competition as a means for improving the variety and performance of services while at the same time encouraging integration and co-operation<sup>10</sup>. However there is concern that performance incentives in the current system may also be inhibiting shifts in the pattern of health care<sup>11</sup>. Despite the significant attention given to commissioning the King’s Fund noted that there was ‘a widespread view that it has not lived up to expectations or delivered its intended benefits’<sup>12</sup>. The RCN believes that a key weakness in commissioning lies in the continuing absence of strong clinical leadership and input at strategic and operational level.

<sup>8</sup>Department of Health (2008), *High quality care for all: NHS Next Stage Review final report*, London: DH (Darzi, A)

<sup>9</sup> Department of Health (2007) ‘*The NHS in England: The operating framework for 2008–09*’. London:DH

<sup>10</sup>Ham, C (2009) *Policy Options for Integrating Health and Social Care*. London: Nuffield Trust

<sup>11</sup>Harvey, S and McMahon, L (2008), *Shifting the Balance of Health Care to Local Settings*. London: The King’s Fund

<sup>12</sup>Curry, N., Goodwin, N., Naylor, C. and Robertson, R (2008) *Practice-based commissioning: Reinvigorate, replace or abandon*. London: The King’s Fund

To be successful the process of commissioning 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 focussed<sup>13</sup>. Current pre-registration education does not prepare them well for that environment; 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.

**The specific recommendations from the RCN are:**

- **nursing perspectives on patient care pathways need to be deliberately included in commissioning process at practice and PCT level. Currently nursing is excluded which the RCN believes diminishes the commissioning process**
- **the commissioning and provider split should not become a “Berlin Wall”. There needs to be genuine co-operation and integration between care pathways to ensure high quality patient focused services**
- **community pricing should reflect packages of care delivered by skilled multidisciplinary teams on the basis of patient needs. Simply paying for activity or according to diagnosis alone will not deliver the right incentives.**

**3. Patient mobility and choice – the role of the nurse**

The notion of patient mobility and choice is firmly embedded in policy and to a certain extent in practice. Recent involvement of private and independent companies in the delivery of NHS care has demonstrated how practical considerations such as information flows, patient pathways and performance criteria must be clearly laid out in advance of a patient journey. Even with detailed and prescriptive contracts between commissioners and private providers and the concerted effort of national government, there have still been widespread concerns about patient selection, variations in quality of care, value for money and staff training and development<sup>14</sup>.

At the EU level, the reality is that cross border care has a relatively small impact on the overall number of patients treated within and outside the NHS. The UK only shares one land border with another EU member state (Republic of Ireland and Northern Ireland). There have been studies by the EC on the extent of patient mobility and what issues this has raised for patients,

<sup>13</sup> Wortham, K (2007) '*Clinical leadership for NHS commissioning: Exploring how allied health and other health professionals lead change through and beyond commissioning for a patient led NHS*'. London: NHS Alliance

<sup>14</sup> See for example the evidence to the House of Commons Health Select Committee on 'Independent Sector Treatment Centres' (Fourth Report of Session 2005–06, Volume I) July 2006

politicians, providers and commissioners<sup>15</sup>. Even where concrete figures exist (mostly for a limited range of acute or hospital based treatments), the actual numbers of 'mobile' patients ranges from 0.3 – 0.6% of total patient numbers treated in Eire and Northern Ireland.

**The RCN's key recommendations in terms of separation of patient mobility and choice are as follows:**

- **the role of the nurse is key in dealing with the challenges of patient mobility. They are able to ensure continuity of care including acting as information broker, assessor, planner and deliverer of care**
- **information systems remain underdeveloped in this area, particularly around communicating nursing care in a consistent manner. Nursing content standards in the electronic patient record will help ensure that patient information is communicated effectively between providers.**

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<sup>15</sup> Rosenmöller, M., McKee, M. and Baeten R (2006), *Patient Mobility in the European Union: Learning from experience*. EU Health Observatory.

## The evidence on the costs and benefits of nursing

### Costs (or inputs)

The costs of nursing can be identified relatively simply; in essence the wage bill for nursing staff. The precise costs of nursing reflect both central and local decisions about wage rates, nurse numbers, skill mix (higher skilled workforce will typically cost more), education, training, and international, national and local labour market conditions.

### Benefits of nursing (or outputs and outcomes)

The benefits of nursing are somewhat more difficult to identify. The term benefit is used interchangeably with value. There are a number of reasons why identifying the value of nursing is a challenge:

1. the value of nursing includes both tangible and non-tangible components and intangible components are inherently difficult to identify and measure
2. it can be difficult to separately identify the contribution of nursing to health. (alongside the wider issues of measuring the contribution of the health care system in general, to the production of health)
3. the value of nursing includes the impact on patients, their carers, the health care system, and the wider economy. This poses a challenge to capture the value to each of these stakeholders in the system.

It also means it is difficult to know, at any given level of nursing input, whether this is optimal or whether more (or less) nursing is a wise choice. Optimising nursing value in a complex system must also recognise that culture, education and support, for example, will influence the way that individual nurses can, and will work, and the subsequent value of that work.

### Evidence on tangible value

Nurses across the health and social care system complete a variety of activities (or deliver outputs) which reflect a myriad of factors including patient needs, sector, setting, skills etc and cover health prevention and education as well as care.

The link between nursing and (production of) health is becoming increasingly clear from a variety of pieces of evidence. This paper does not go into detail but rather sets out where there is evidence that nursing directly impacts upon health and other relevant outcomes. This is set out in table 1 below.

**The RCN recommends that quality indicators should be developed which reflect nursing and not just medicine.** This recommendation is reinforced in the King's College National Research Unit paper on *State of the*

*art metrics for nursing*<sup>16</sup> which stated that if indicators are to be useful then they must be measurable with available data at reasonable cost. There must be evidence that the quality and quantity of nursing substantially contributes to changes measured by the indicator. The indicator must be recognised as important (by the public, managers and nurses) and nursing's contribution must be recognised (by nurses and others).

### **Intangible value**

The evidence base discussed above is focused upon some of the tangible value of nursing. It does not however explore the more intangible value of nursing. Although not fully empirically tested it's likely that patients will derive reassurance from the care provided by nursing (or this might be expressed as reduced fear).<sup>17</sup> The RCN has made significant progress in this area through its Dignity campaign which sought to highlight the intangible though fundamentally important aspect of care<sup>18</sup>. This is not as readily amenable to measurement as more traditional outcomes such as mortality, length of stay, for example, are. However there are more tools available to explore and attempt to measure intangible value and these have much to offer. Such tools include stated preference techniques (often called willingness to pay studies).

Again, whilst not fully empirically tested, nursing may provide value in being a resource that can be deployed in times of emergencies. It is plausible that there is inherent value in knowing that should a crisis occur that there are nursing resources, alongside other system resources, to help mitigate against the worst health impacts of such events.

**The RCN's key recommendation in terms of intangible quality is that 'real' patient-reported outcomes measurements (PROMs) need to be effectively captured** — in other words, outcomes of direct importance and relevance to the patient. However not all PROMs are reliable and able to generate valid data in terms of effective care delivery.

### **Incremental value of more/less nurses**

The 'total' value of nursing will depend upon the current number, skill mix and the ways that nursing staff are deployed. There is increasing evidence of the negative consequences of reducing nurse numbers from the Healthcare Commission when they have investigated higher than expected levels of patient mortality.<sup>19</sup>

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<sup>16</sup> 'State of the art metrics for nursing: a rapid appraisal' National Nursing Research Unit, Peter Griffiths with Simon Jones, Jill Maben and Trevor Murrells. 2008

<sup>17</sup> See A Fareed (1996) for some discussion of reassurance. 'The experience of reassurance: patients' perspective' *Journal of Advanced Nursing*. 23, 272-279

<sup>18</sup> RCN (2008) *Dignity, at the heart of everything we do*. London: RCN

<sup>19</sup> See Healthcare Commission Investigation into outbreaks of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust (2007). See also 'Nurses in society: starting the debate' (15th October 2008) and P Griffiths et al (2007) 'State of the art metrics for nursing: a rapid appraisal' and Manley K (2000) 'Organisational culture and consultant nurse outcomes: Part 1 organisational culture' *Nursing Standard*;14:34-38 and Manley K (2000) 'Organisational culture and consultant nurse outcomes: Part 2 consultant nurse outcomes' *Nursing Standard*;14:34-39. The RCN could also pass on other relevant references upon request

**Table 1: summary evidence: nursing impact on processes and outcomes** <sup>20</sup>

Processes/Outcomes	Sources
<p><b>Saving lives</b></p> <p>Reduction in mortality</p> <p>Correlation between nurse staffing levels and crude mortality</p> <p>Correlation between nurse ration and HSMR</p>	<p>Tourangeau et al (2006)<sup>21</sup></p> <p>Dall et al (2009)</p> <p>West and Rafferty (Undated)<sup>22</sup></p> <p>Rafferty et al. (2006)<sup>23</sup></p> <p>Dr Foster (2009)<sup>24</sup></p>
<p><b>Improving health and improving quality of life</b></p> <p>Lower rates of medication errors and wound infections</p> <p>Lower rates of pressure ulcers, hospital admissions, urinary tract infections, weight loss and deterioration in ability to perform activities of daily living</p> <p>Improved mental and physical functioning, reduction in depression</p> <p>Smoking cessation</p>	<p>McGillis Hall et al. (2004)</p> <p>Horn et al (2005)</p> <p>Markle-Reid et al. (2006)</p> <p>University of Ottawa Heart Institute (2007)</p>
<p><b>Cost effective care</b></p> <p>Reduction in length of stay</p> <p>Reduced length of stay and adverse events avoided can lead to net cost savings</p>	<p>Kane et al. (2007)</p> <p>Needleman et al. (2002)</p> <p>Needleman et al. (2006)</p>
<p><b>Process of care</b></p> <p>Reduction in waiting times</p> <p>Improvement in patient experience and perception of health care</p>	<p>CAN (2009)</p> <p>Rafferty et al. (2006)<sup>25</sup></p>
<p><b>Contribution to wider economy</b></p> <p>Increasing the number of RNs per patient has an estimated value of US\$60,000 per additional FTE positive in avoided medical costs and improved national productivity (US)</p>	<p>Dall et al. (2009)<sup>26</sup></p>

**Note:** RN = Registered Nurse; FTE = Full Time Equivalent; and HSMR = hospital standardised mortality ratio

<sup>20</sup> All references cited in [www.cna-aiic.ca/CNA/documents/pdf/publications/ROI\\_Value\\_Of\\_Nurses\\_FS\\_e.pdf](http://www.cna-aiic.ca/CNA/documents/pdf/publications/ROI_Value_Of_Nurses_FS_e.pdf) unless other wise stated

<sup>21</sup> Tourangeau, A E et al Impact of hospital nursing care on 30-day mortality for acute medical patients, *Journal of Advanced Nursing*, 57(1) pp.32-44

<sup>22</sup> West, E and Rafferty, AM, *The Future Nurse: Evidence of the Impact of Registered Nurses*

<sup>23</sup> Rafferty, A M et al Outcomes of variation in hospital nurse staffing in English hospitals: Cross sectional analysis of survey data and discharge records, *International Journal of Nursing Studies* (2006) doi:10.1016/j.ijnurstu.2006.08.003

<sup>24</sup> Dr Foster Intelligence, *Nursing Times*, 31<sup>st</sup> March 2009

<sup>25</sup> Rafferty, A M et al Outcomes of variation in hospital nurse staffing in English hospitals: Cross sectional analysis of survey data and discharge records, *International Journal of Nursing Studies* (2006) doi:10.1016/j.ijnurstu.2006.08.003

<sup>26</sup> Op Cit

However it must be recognised that there may well be diminishing marginal returns from adding each additional nurse. The challenge is that it is difficult to identify whether the system as a whole is near or far from the point where adding a further nurse would make a very large or small additional contribution to health. More research is needed to help decision makers understand:

1. the minimum number and skill mix of nurses to provide safe, effective care
2. the impact of adding more nurses and whether this is worthwhile, and ways to optimise their value (which is a reflection of the human nature of the workforce and the systems, culture etc in which nurses work) and recognises that it is not simply nurse numbers which matter.<sup>27</sup>

This research could explore the relevance and use of indicators for both nurse inputs and outcomes. The weight of evidence which shows that reducing nurse staff numbers can compromise safety and consequently costs lives is significant. The converse is also true, adding nurse staff numbers with appropriate skill mix etc can ensure safety and positively contribute to saving lives and improving quality of life for patients. Decision makers therefore need to avoid making short term decisions, ensuring that they consider the full value of nursing, and the negative consequences when nurse numbers are reduced, when considering how to best allocate scarce resources in the health care system.

**The RCN's key recommendation in terms of the incremental value or more/less nurses is as follows:**

- **Nurse staffing matters because of the evidence that links patient reported outcomes to registered nurse input<sup>28</sup>**
- **The RCN continues to recommend that a skill mix ratio of 65% registered nurses to 35% health care assistants in the benchmark for the general ward nurse staffing establishment**
- **Staffing levels are one of the key priorities for nursing because this will affect patient safety and quality of care on a day to day basis**
- **Previous studies by the Audit Commission have shown that higher levels of bank and agency nurses compared to established posts can result in lower levels of patient satisfaction<sup>29</sup>**

<sup>27</sup> See California Healthcare Foundation, *Assessing the Impact of California's Nurse Staffing Ratios on Hospitals and Patient Care for a discussion of the complexities of nurse staffing ratios and their impact*

<sup>28</sup> *Setting Appropriate Ward Staffing levels in NHS Acute Trusts*, RCN Policy Unit Guidance, September 2006

<sup>29</sup> Audit Commission, *Acute Hospital Portfolio - Ward Staffing*, 2001

- **trust boards must assure themselves they have the necessary tools in place to ensure safe staffing levels. Quality indicators can provide valuable resources to enable better understanding of appropriate staffing levels and provide assurances for effective patient care.**

### **Substitution**

There is some degree of substitution over who could provide certain activities in the health care system and contribute to generating health. There is evidence that for some activities patients may prefer a nurse over a doctor. For example, patients with hypertension have been shown to respond better to nurse practitioners delivering health promotion and chronic disease management (Canadian Health Services Research Foundation 2002<sup>30</sup>). Nurse led follow up of children has also been shown to be as effective as follow up by a paediatrician and the cost was 17.5% lower (in the Netherlands) (Kamps et al., 2004)<sup>31</sup>. More research is needed to understand where nurses are just as effective as other staff (who are more expensive); and where nurse delivered services are valued more by patients than the same services delivered by other staff.

**The RCN recommends that further research on substitution should be undertaken to advance the knowledge on the economic value of nursing.**

As Rutherford (2008)<sup>32</sup> notes, “Valuation of nursing services will be needed to support the importance of investing in nursing services in order to improve the overall outcomes of future health care”. There is in particular a lack of research on the value of nursing in the non-acute setting. This research needs to be considered from both a tangible and intangible value perspective. Some promising areas to explore further include:

- using the stated preference approach to begin to further explore and capture the largely so far, intangible value of nursing to patients and carers
- increasing measurement and benchmarking of nurse inputs and activity since nurse input is relatively invisible in Payment by Results
- increasing measurement and benchmarking of nurse inputs and activity in areas which are not currently covered by PbR, especially in non-acute settings

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<sup>30</sup> As cited in [www.cna-aicc.ca/CNA/documents/pdf/publications/ROI\\_Value\\_Of\\_Nurses\\_FS\\_e.pdf](http://www.cna-aicc.ca/CNA/documents/pdf/publications/ROI_Value_Of_Nurses_FS_e.pdf)

<sup>31</sup> Op Cit

<sup>32</sup> Rutherford, MM The How, What, and Why of Valuation of Nursing, *Nursing Economics*, November-December 2008.vol26/No. 6 p347-351

- increasing measure and benchmarking of processes, outputs and outcomes including common measures (such as EQ 5D<sup>33</sup>)<sup>34</sup> so that we can compare across wards, hospitals, and across settings
- using econometric analyses which can use a common output measure (such as EQ 5D data being collected as part of the DH PROMS work) combined with input data to explore the relative contribution of nursing versus other inputs.

These are suggestions and the feasibility and practicality of these will need to be explored.

It is also important to recognise that it is not simply about better data and better research, but also about changing culture. Decision makers and nurses need to understand the value of measurement and benchmarking and also ensure that this leads to improved decision making that is both transparent and inclusive.

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<sup>33</sup> EQ 5D is a generic quality of life tool which covers 5 domains (mobility, self care, usual activities, pain/discomfort, anxiety/discomfort. See <http://www.18weeks.nhs.uk/Asset.ashx?path=/Pathways%20-%20guidance%20and%20docs/EQ5D.doc>

<sup>34</sup> See also Griffiths, P et al., *State of the art metrics for nursing: a rapid appraisal (2008) for further discussion of measures*

## Cultural attitudes towards the nursing profession

The future value of nursing should not only be seen through economic analysis alone. The dynamics that give an enduring value to the status of nursing in any country will be characterised by the different cultural perspectives that are brought from the Government of the day, nurses themselves, the management of the health sector, and from citizens whether as members of the public or as patients. Each of these different groups will have a distinct attitude to the profession of nursing and to the individual contribution made by nurses themselves. There are the inevitable tensions and contradictions among each group and their impact on health systems.

### Citizens

Citizens are being encouraged to have higher expectations of services. They are no longer content to be passive recipients; they want to be active partners. Many commentators have called for a renewed culture of social partnership and participation and this is now mainstream policy for the Department of Health. Government ministers are increasingly conscious of the constant challenge to ensure that people are involved, making that process part of the daily lived experience of nursing.

The policy direction to increase the role and responsibility of the citizen in health is potentially contradictory. It is important for government that patients are regarded as citizens with a voice in shaping services from below. However, attempts to increase the actual authority have been limited and the RCN has been disappointed in the very limited legal duty of responsibility for the NHS Constitution in the current Health Bill. It is critical for the continued belief of the citizens in the NHS that there is a shift in cultural approach. The RCN campaign on Dignity highlighted these tension - nurses needed to be reminded of the need to provide dignified care at a time when increased technology has brought an increased risk of treating patients as 'throughput' in the delivery of targets. These risks now need to be rebalanced using the fundamental principles of nursing care.

### Management and structure in the health sector

The frequency of significant organisational changes in NHS has been both a help and a hindrance to nurses and citizens. For example the upheaval caused by major reform to PCTs and Strategic Health Authorities (SHAs) in England led nurses to spend significant amounts of time reapplying for the same post.

The creation of national regulatory structures (Care Quality Commission, Monitor, NICE, National Patient Safety Agency) has created arm's length organisations each with defined functions. This brings a greater sense of clarity for nurses and citizens about the distance being created between the politics of the NHS and the day to day delivery of the health service in

England. Nurses have been able to engage with the development of quality care through NICE, and to influence the manner in which national regulation can improve patient care.

Regulation is now becoming increasingly important in the context of an NHS and social care system in England with:

- *commissioning*, either undertaken by PCTs or commissioning outsourced to independent sector providers deciding what to buy and from whom
- *patient choice and voice* allowing patients' choice over their provider and more consultation and engagement with patients. In addition, the potential for greater scope of personal or individual budgets for some individuals in both health and social care to purchase those services which best meet their needs
- *plurality of providers* including Foundation Trusts, the independent sector and the third sector (including for example, charities and social enterprises)
- a renewed *focus on quality* as part of the Next Stage Review
- a new *NHS constitution*.

Regulators therefore need to respond to a more diverse provider base and plan for the longer term. If the number and type of providers is increasing, it is important to ensure that they operate in ways that deliver high quality, safe care. The CQC (and others) have a role to play in setting standards and monitoring providers<sup>35</sup>. In particular, the CQC has a number of enforcement powers ranging from fines through to closing a provider down; the CQC therefore can bring to bear strong incentives for providers to ensure that they deliver high quality safe care. It is essential that CQC has effective powers to mark it out as a robust and effective regulator as well as being given sufficient time by government to 'bed down'.

**The RCN's key recommendation in terms of supporting cultural change is as follows:**

- ***education*** - management training for nurses could include a component on how national policy is made and shaped through a programme similar to 'Westminster Explained'. The RCN has a successful political leadership programme that assists nurses in understanding political reality and the influence on policy making. Local councillors and MPs could be encouraged to undertake shadowing

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<sup>35</sup> *The Regulatory Landscape in Health and Social Care in England in 2009*, RCN Policy Briefing, June 2009

opportunities with nurses from their constituency.

- **transparent decision making – more decision making needs to be 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 will 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 reported in its oral evidence to the Health Select Committee that nurses who reported unsafe incidents at Mid Staffordshire Hospital were informed that their concerns were 'being placed in a waste paper basket'
- **nursing leadership - it is vital that the voice of nursing is adequately represented in the governance of the NHS at all levels.** The value that nurses at board level bring means that nurses at all levels in the NHS can be enabled to deliver on quality care, including safety, dignity, care and compassion - the core values of nursing. The nurse director is the 'lynchpin' to achieve cultural change with the ability to develop a comprehensive view of the patient journey and the challenges associated with it. In addition to delivering core front line services, nurses provide high quality, leadership, management and supervision.

The RCN has published a policy position on the need for an executive director of nursing to be on the board of each PCT, 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.

## Diversity of workforce

The College believes that nursing workforce should fully reflect the community that they serve at all levels of an organisation, particularly in positions of leadership<sup>36</sup>. Equality of opportunity and valuing diversity should be mainstreamed throughout every organisation. All employees should be able to enjoy working in an environment that is free from unlawful discrimination, victimisation and harassment, along with freedom to develop, achieve and excel within and beyond their existing roles. Achieving equality and diversity within an organisation requires an explicit and concrete long-term commitment and vision, which is integrated into both the strategic and operational elements of the organisation's activities.

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<sup>36</sup> NHS Black and Minority Ethnic Leadership Forum Report (2003-06) RCN London

## Nursing, Personalisation and social Care

Lord Ara Darzi noted on 25 March 2008 that “increasingly, the boundaries between health and adult social care are becoming less defined. A person’s treatment will often require care in a range of settings”<sup>37</sup>.

In terms of the context of care, the *Wanless Report*<sup>38</sup> concluded that most individuals in the UK would prefer to receive care at or close to home and that most would prefer ‘prevention rather than cure’. By contrast, the services which are available at present are still primarily focused on people with high end needs, and are substantially provided in care homes.

The so called ‘acute to community shift’ is actually a complex long standing policy debate founded on practical concerns such as cost, the availability of specialist care and the suitability of environments as the setting for some types of care.

Nurses and nursing care increasingly sit at the interface between acute and community settings which increasingly has the potential to be a flashpoint. However there are now also significant opportunities for nurses to take the lead and work across the traditional boundaries of care ensuring that the patient remains at the very centre of the care pathway. Increasingly nurses are becoming ‘co-ordinators and navigators’ of care as well as specialists in long-term conditions.

### The RCN recommends:

- **education, training, organisational and funding arrangements for nurses will need to change to ensure that there is sufficient capacity in the system to meet the demand and bring care ‘closer to home’ for patients**<sup>39</sup>
- **continuity of care depends on effective relationships between professionals as well as clear communications with the patients receiving the care. Nurses will play a central by advocating patient centred care pathways and new business models designed around actual need and by co-ordinating the quality of the care episodes across boundaries.**

<sup>37</sup>Lord Darzi of Denham, the Parliamentary Under Secretary of State for Health (Hansard, column 449) - statement to House of Lords on the Health and Social Care Bill – 25.3.08

<sup>38</sup>D Wanless (2006) ‘*Securing good care for older people: taking a long term view*’. The Kings Fund, London

<sup>39</sup>Sibbald, McDonald and Roland, Shifting care from hospitals to the community: a review of the evidence of quality and efficiency, Journal of Health Service Research and Policy, volume 12, page No 117-117 2007

In terms of personalisation, the government's agenda for health and social care is clearly set out. The Transforming Social Care agenda outlined in the ministerial concordat *Putting People First* (2008) states that all adult social care users should be offered a personal budget if they want one. The Department of Health has already announced a pilot programme for personal health budgets in 2009 as part of the implementation of the NHS Next Stage Review. The NHS operating framework 2009/10 and the ongoing discussion around the Adult Social Care Green Paper add additional impetus to the personalisation agenda. The key features of personalisation broadly speaking are

- respecting the dignity and autonomy of every patient
- understanding that no two patients are the same – they each have unique circumstances, wants and needs, to which we need to respond
- understanding the whole patient experience, from start to finish
- providing choice for patients about when and where they access care
- access to easily accessible information to assist patients making choices.

Broadly, international evidence is supportive of the issue of personalisation. In the case of direct payments, the available evidence points to the strong potential for greater user satisfaction, greater continuity of care, fewer unmet needs and a more cost effective use of public resources<sup>40</sup>. However innovation will have to be balanced with clear thinking on patient safety, critical mass of human and other resources, and suitable channels of communication to prevent duplication or omission.

**The RCN's key recommendations in terms of personalisation and social care are as follows:**

- **as far as the future for nursing is concerned, a shared vision and collective responsibility for creating a positive attitude to change is essential<sup>41</sup> to ensure personalisation is a success at all levels**
- **outreach and tailored support will need to be available if personalised services are to be made available to the most excluded in society who are least well served by the NHS**
- **in regard to funding streams there is a need for a clear delineation between health and social care, where lack of clarity can mean**

<sup>40</sup> Prof J Glasby (2008) '*Individual Patient Budgets: Background and Frequently Asked Questions*' Health Services Management Centre (HSMC), University of Birmingham

<sup>41</sup> Manley, K., Sanders, K., Cardiff, S., Garbarino, L. and Davren, M (200) 'Effective Workplace Culture'

**patients are prevented from receiving the right support from the right service**

- **the RCN would support the introduction of an ‘assigned nurse’ to act as a link along the full length of the care pathway for those with long term conditions. They would co-ordinate the individual’s overall case management and maintain an in depth knowledge of the patient’s ongoing conditions (including clear information on self management and how to access service provision)**
- **nurse specialist posts for long-term conditions should continue to be developed and evaluated. Early evidence shows that early intervention by specialist nurses can prevent unnecessary admission to hospitals.**

## Public Health

Nurses have a significant ability to influence behavioural change within a health promoting environment. Nursing achievements in the public health sphere are visible and measurable, impacting on individuals, specific groups and the population at large. The RCN Document '*Nurses as partners in Delivering Public Health*' identifies a number of aims in delivering public health through nursing services:

- increase life expectancy by influencing healthy behaviours
- reduce health inequalities – for example, targeting vulnerable populations to improve health outcomes and access services
- improve population health – For example, reducing obesity, alcohol abuse, improving sexual health behaviour
- increase the awareness of positive healthy behaviours in communities
- promote and develop social capital
- engage with individuals, families and communities to influence service design.

The benefit from achieving these goals is significant and reduces the future burden to the NHS by delaying or preventing illness. While there are many visible examples of public health nursing that make a substantial contribution to this, there is a lot of good public health nursing practice that is carried out locally but does not achieve widespread recognition.

The following examples serve to illustrate how innovative nursing practice has been. Nursing's position in public health could be strengthened to encourage further innovation in this area.

### 1. *The Family Nurse Partnership (FNP) Programme*

The FNP is a programme designed to assist vulnerable, first time, young parents by providing them with support that begins in early pregnancy and continues until the child is two years of age.

The programme is licensed and structured and has been developed over 25 years in the US where it was subject to three large-scale controlled trials. Some of the benefits include: reductions in children's injuries, fewer subsequent pregnancies, increased paternal involvement, increases in employment and earnings and reduced arrests and criminal behaviour in children and mothers. It has been running since 2007 in the UK and is delivered by specially trained family nurses often with a background in health

visiting, midwifery, mental health or school nursing. Each nurse normally takes on a caseload of about 25 mothers.

US research suggests that the scheme is highly cost effective and that savings to the community are four times the amount spent. Early indicators in the UK look promising and the government has expressed a desire to expand the service to reach more vulnerable, first time mothers.

## *2. Health for Youth through Peer Education (HYPE)*

HYPE is a youth centred programme in Belfast using an innovative approach to promoting sexual health to young people under 25. The programme uses a multidisciplinary team of peer educators and health professionals to increase the uptake of services; reduce sexually transmitted infections; and achieve a reduction in unintended pregnancies. Nurse-led outreach services tailor education programmes for specific groups and individuals.

These are both excellent examples of nurse lead innovation in public health in an unlikely setting. Only brief training of a few days is necessary for nurses to provide this type of intervention with a measurable and lasting public health benefit. The NHS Next Stage Review identified that there will be new education and development opportunities for specialist community public health nurses, including for health visitors.

**The RCN's key recommendations in terms of public health are as follows:**

- **in order to encourage innovative nursing practice in public health nurses should have support and access to training**
- **measuring the socio-economic benefit of public health practice involves considering health gain and also cost effectiveness. Public health nursing carries a short and long term benefit; many of the short term health gains such as reduced STI transmission are easily identifiable but the longer term benefits require more diligent and committed appraisal as they are not immediately identifiable (for example, a reduction in alcohol related liver disorders in old age)**
- **an obstacle to realising these goals fully is the lack of research into the effectiveness of all areas of public health nursing. Most of the evidence base for effectiveness of public health nursing comes from areas of health promotion such as smoking cessation. More research needs to be conducted into public health practice effectiveness.**

# Summary of recommendations

Royal College of Nursing submission to the Prime  
Minister's Commission on Nursing and Midwifery

**Note:** *The Royal College of Nursing welcomes the opportunity to submit papers for the Prime Ministers Commission on the future of Nursing and Midwifery. Please note that the attached paper is one of five that the RCN has provided to the Commission to enable it to take forward its important work. Readers should be aware that there are a series of key themes and recommendations that run across all five documents submitted by the RCN and no individual paper should be considered in isolation. All the documents describe the role of the nurse now and in the future as well as commenting on the value of nursing, both qualitatively and economically, and its relationship with and influence upon wider society. When themes are covered in more than one paper we have included a cross reference wherever possible.*

## Summary of recommendations

### A new vision of nursing and midwifery

The RCN's key recommendations are as follows:

- i. Service improvement demands that commissioners focus on patient care pathways, rather than commissioning different services in different settings. Examples of such approaches where care has been significantly improved as a result include those pertaining to the management of strokes, and heart failure.<sup>1</sup>
- ii. More could be done along the nursing career pathway to ensure a visible commitment to nurturing equality and diversity in the workforce, which can help the NHS and other employers in health and social care to comply with legislation and public policy; improve public image; and recruit and retain talented and motivated staff from BME and other backgrounds. We are particularly keen to see sustained progress in addressing inadequate representation at leadership levels from amongst BME groups.
- iii. The development of services, according to care pathways means that the nursing workforce must have transferable skills and knowledge, and be capable of caring for patients in both the hospital and community. Nursing will be mobile, always going where their patients happen to be, rather than being fixed in one building or institution.
- iv. Nurse educators will need to be capable of preparing a nursing workforce which is able to safely transfer from one setting to another, and always providing high-quality care. Wherever people are receiving nursing, their care will be underpinned by all the elements which promote dignity, reassurance, positive health outcomes and safety. It is critical to patient safety that all nurses have an in depth understanding of the basic elements of care, eg. post operative observations, nutrition and hydration, personal hygiene and record keeping.
- v. The 21<sup>st</sup> Century nurse must have an understanding of public health and, regardless of their main place of work, promote health and equality; develop the skills and knowledge to work effectively with older people; take the right action to prevent disease and identify it at the earliest possible opportunity.
- vi. 70% of health care is nursing, which is by far the major provider of care within the NHS and independent provider organisations. If health care organisations were committed to ensuring that nursing was well led, resourced and supported, it is likely that patients would be safe while in their care.
- vii. It is essential for health care organisations to focus on the quality of all levels of nursing care, from fundamental and basic nursing through to specialist and advanced practice. Lives are saved and the patient experience improved when we ensure this happens, yet when finances have to be saved it is often nursing which is reduced before other disciplines. We must learn lessons from the Maidstone and Mid Staffordshire hospital experiences.

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<sup>1</sup> Getting better: Using Stroke Services across the UK. Stroke Association 2009)

- viii. The highest quality care is provided at the least cost to the organisation. It is poor care which brings added financial burdens to the health care organisation. Money is not saved by reducing nursing numbers and diluting skill mix. Patient experience and health outcomes are improved through deploying adequate nurses and health care support workers at the appropriate skill mix to best meet patient needs. The RCN Ward Sister Project demonstrates the added value that well-prepared and supported ward leaders bring to patient care.
- ix. The RCN supports the ambitions and aspirations of Transforming Community Services and is keen to work with the DH on its implementation.
- x. 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. We must constantly reflect on how the public sees nursing, what it expects from us and how we need to adapt to meet changing expectations and needs.

## Workforce and leadership

The RCN's key recommendations are as follows:

- i. Agree the definition of a nursing staff vacancy to ensure more accurate assessment of the state of the labour market.
- ii. Acknowledge that there is an emerging potential mismatch between supply and demand as an important first step to dealing with the issue of shortage.
- iii. 'Join up' workforce planning including input from the devolved administrations and the independent sector.
- iv. Invest in specialist bridging training for hospital based nurses. This will require a period of increased investment in the overall number of nurses to maintain good quality of care while the workforce is being developed to deliver the demands of the service.
- v. Provide a requirement for all health care provider employers to sign up to a level of support, supervision, provision of professional leadership for nursing staff.
- vi. Commit to tackling physical violence and verbal abuse towards nurses and other health care workers by prosecuting their attackers and investing in measures to reduce the risks of violence to all, including lone workers.
- vii. 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 health care staff.
- viii. Legislate for a preventative approach to the protection of nurses and other health care workers from potentially life threatening needle stick and sharps injuries including the provision of safer needle devices and systems.
- ix. Protect the health and safety of nurses, patients and other health care workers by ending the practice of opting out from the 48-hour working week and ensuring compensatory rest for those who work on-call.

- x. Ensure that nurses who raise concerns in the workplace are protected when they speak out.
- xi. Commit to workplace representation and partnership working as an effective way of managing staff relations.
- xii. Engage nurses in the debate about the competences required for world class commissioning to ensure that competence in continuous improvement of the quality of care is seen as essential in good procurement as financial skill.
- xiii. Provide protected training time as part of continuous professional development for nursing staff and health care assistants and provide all newly registered staff with preceptorship.
- xiv. Ensure regular nurse staffing reviews in all health care settings to ensure appropriate staffing levels that meet patient needs, ensure patient safety and quality care.
- xv. Do not reduce nursing staff grades or alter skill mix solely on financial grounds.
- xvi. Regulate Health Care Support Workers.
- xvii. Invest in the development of nurse leaders that can make a positive difference to the experience of patient care
- xviii. Provide appropriate support and development for existing nurse leaders, regardless of their position or role.
- xix. Provide leadership programmes to all those taking on ward sister posts as an essential pre-requisite to taking on this role.
- xx. Invest and develop strong nursing leadership that challenges the status quo and identifies areas of change and how change can be achieved.
- xxi. Commit to the development of nurse leaders who are skilled at working across organisational boundaries and creating alliances.
- xxii. Greater focus and investment in developing nurses as leaders and managers of quality patient centred care of multi-disciplinary teams.
- xxiii. Ensure nurses have access to development opportunities that enable them to confidently lead multi-disciplinary teams and team development
- xxiv. Commit to developing nursing leaders who are skilled in taking the lead for working with and implementing national strategies for health improvement.
- xxv. Ensure access to tailored leadership and management development programmes, peer review, mentorship and shadowing opportunities for all ward sisters and senior clinical nurse leaders.
- xxvi. Urgently review the role of clinical leaders in community settings.
- xxvii. Investment in nursing leadership around eHealth, the e-agenda, telehealth and telecare that enables nurses to take the lead for innovative communication methods and new services.

- xxviii. Invest in nursing leadership in both commissioning and providing services in the changing world of health and social care.
- xxix. Development of senior and executive nurses to confidently influence, be influential and political.
- xxx. A commitment to ensure that all leadership initiatives and opportunities are sustainable.

## Helping and hindering forces

The RCN's key recommendations are as follows:

- i. **Nursing leadership** – investing in the preparation of nurses for taking on leadership roles in a variety of health care settings that drive up standards and enhance patient care within and across organisations, specifically:
  - a. an urgent review into the ward sister role together with a commitment to investing in their training and development
  - b. a review of the nursing team leadership role in community and primary care settings and an assurance of investment in their training and development as a pre-requisite to taking up post
  - c. investment in nurses' team leadership skills to equip them to effectively lead and manage skill mix in multi-disciplinary teams, in both primary and secondary care settings.
- ii. **Quality** – investing in the nursing workforce as a key role for nurses and nursing in driving high quality services (please see attached RCN paper on quality and innovation for more detail), specifically:
  - a. invest in nurses' ability to lead for quality, standards and metrics when planning for workforce development programmes
  - b. commitment to invest in nurses' training and development to ensure they are confident in their use of the new technology available to enhance quality patient care
  - c. that commissioners ensure that there are mechanisms in place that enable nurses to share evidence based good practice across all provider organisations that enhances high quality patient care.
- iii. **Workforce** – there is an urgent need to review the a range of issues concerning the existing nursing workforce (please see attached RCN paper on workforce and leadership for further detail), specifically:
  - a. commitment to prepare all ward sisters (and their equivalent in primary/community settings) adequately in non-clinical skills development as a pre-requisite to taking up their role. The RCN considers that this investment should focus on leadership and management training that is transferrable across the acute and primary care sectors

- b. implementation of appropriate ongoing support mechanisms for nurses that help them to work effectively across boundaries, professions, teams, organisations and cultures and help foster strong working relationships
  - c. a requisite that all new health care providers should have a well-developed CPD plan for nurses as part of their business submission
  - d. better workforce planning, taking into account the need for succession planning and the anticipated changes in demand from the increasingly ageing population, chronic illness and co-morbidities
  - e. recognising the importance of and investing in providing responsive training that allows nurses to be confident in the shifting arena of health care delivery and take on the leadership of increasingly multi-disciplinary teams.
- iv. **Culture, diversity, equality and human rights**
- a. Urgent action is required on the part of nurse educators to develop and embed distinct components on both pre and post registration.
  - b. Education as well as continuing professional education that enables nurses and midwives to understand and implement equality, diversity and human rights into their practice.
- v. **Patients, the public, nurses and nursing**
- a. The RCN calls for action to promote the image of nurses and to portray their role in a positive manner, that their role is described in an honest and factual way so that the public have a better understanding and clearer expectations of nurses.
  - b. Greater investment in organisational development training and development opportunities (non-clinical skills development) for nurses that equip them with the skills and knowledge to challenge existing disabling cultures and to promote those that enable positive ways of working.
- vi. **Nursing in a changing society** - The RCN views nurses as key information and knowledge workers, who give the public accurate and high quality, evidence based health information, and as professionals who make decisions and solve problems based on sound knowledge information.
- a. The RCN calls for improved eHealth systems and processes to enable nurses to carry out this key function now and into the future.
  - b. Greater investment in developing role clarity for new and emerging nursing roles.
  - c. Commitment to investment in skilling up all nurses so that they are better able to influence the commissioning of high quality services.
  - d. An assurance that senior nurse executives will have a place on all NHS trust boards, both in the acute sector and in PCTs.
  - e. An assurance that nurse leadership in the community sector will receive the recognition and commitment for funding of training and role preparation that it requires.

## Quality and innovation

The RCN's key recommendations are as follows:

- i. **Make quality, safety and innovation the backbone of the career framework**
  - a. Implement a curriculum at pre-registration and then post-registration that focuses on the essential standards for the fundamentals of care expected of all nurses and then the development of expertise in person-centred, safe and effective practice.
  - b. Implement a curriculum post –registration that integrates movement towards advanced and consultant nurse practice that focuses on sustaining the provision of quality fundamental care by nursing, as well as, developing expertise in person-centred and whole systems approaches and the facilitation of this in others.
  - c. Implement work-based learning<sup>2</sup>, linked with clinical supervision as a key approach for enabling nurses to continue to provide the fundamentals of care as well as grow their expertise, provide quality, safe and effective care and thus the achievement of both professional and academic accreditation.
  - d. Consider approaches to the quality assurance/revalidation of nursing practice that have at their heart the essential and fundamental aspects of nursing as well as advanced and consultant nurse practice.
- ii. **Invest further in clinical leadership and the clinical career ladder to ensure that sufficient nursing expertise is retained in the workplace where it can directly impact on quality**
  - a. Free up the ward sister to enable a greater quality assurance role in relation to the provision of essential nursing care and the clinical supervision of the nursing team.
  - b. Provide clinical supervision to ward sisters by modern matrons, and consultant nurses to enable continuity of support around their leadership and management role.
  - c. Continue to invest in clinical leadership and the development of expertise in nursing that focuses upon improving the quality of care and reducing patient safety incidents.
  - d. Need for skilled facilitators with the required skill-set to be as near as the interface with patients as possible to enable learning in and from practice, implementation of evidence and standards into practice, individual and team effectiveness, implementation of shared values.
  - e. Systems for systematic evaluation, learning in and from practice and shared governance<sup>3</sup> need to be implemented at the workplace level.

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<sup>2</sup> Everyday work of healthcare is the basis for learning, development (including evidence implementation), inquiry and transformation in the workplace.' (Manley K; Titchen, A; Hardy S (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)

<sup>3</sup> Shared governance encompasses achieving stakeholder participation in using evidence from a variety of sources (e.g. audit, feedback, reflective practice, research) for decision-making

## The socioeconomic case for nursing

The RCN's key recommendations are as follows:

- i. **Incentives for quality and funding reforms**
  - a. Nurses form an integral part of the team for most episodes of care and therefore should be a key focus for quality indicators and for funding reforms. Over recent years nursing teams have re-engineered their roles to assume a higher range of clinical responsibilities, and successfully adapted to use new systems to improve patient care.
  - b. Therefore the nursing contribution to care needs to be explored further in the context of the incentives described above and not simply aggregated as a simple workforce cost.
  - c. Further work on triangulating nursing, patient and service indicators will provide a focus for quality of care and help balance the tensions described above.
- ii. **Separation of provider and commissioner functions**
  - a. Nursing perspectives on patient care pathways need to be deliberately included in commissioning process at practice and PCT level. Currently nursing is excluded which the RCN believes diminishes the commissioning process.
  - b. The commissioning and provider split should not become a "Berlin Wall". There needs to be genuine co-operation and integration between care pathways to ensure high quality patient focused services.
  - c. Community pricing should reflect packages of care delivered by skilled multidisciplinary teams on the basis of patient needs. Simply paying for activity or according to diagnosis alone will not deliver the right incentives.
- iii. **Separation of patient mobility and choice**
  - a. The role of the nurse is key in dealing with the challenges of patient mobility. They are able to ensure continuity of care including acting as information broker, assessor, planner and deliverer of care.
  - b. Information systems remain underdeveloped in this area, particularly around communicating nursing care in a consistent manner. Nursing content standards in the Electronic Patient Record will help ensure that patient information is communicated effectively between providers.
- iv. **Benefits of nursing (or outputs and outcomes)**
  - a. The RCN recommends that quality indicators should be developed which reflect nursing and not just medicine.
  - b. The RCN's key recommendation in terms of intangible quality is that 'real' patient-reported outcomes measurements (PROMs) need to be effectively captured
- v. **Incremental value or more/less nurses**

- a. Nurse staffing matters because of the evidence that links patient reported outcomes to registered nurse input<sup>4</sup>.
  - b. The RCN continues to recommend that a skill mix ratio of 65% registered nurses to 35% health care assistants in the benchmark for the general ward nurse staffing establishment.
  - c. Staffing levels are one of the key priorities for nursing because this will affect patient safety and quality of care on a day to day basis.
  - d. Previous studies by the Audit Commission have shown that higher levels of bank and agency nurses compared to established posts can result in lower levels of patient satisfaction<sup>5</sup>.
  - e. Trust Boards must assure themselves they have the necessary tools in place to ensure safe staffing levels. Quality indicators can provide valuable resources to enable better understanding of appropriate staffing levels and provide assurances for effective patient care.
- vi. **Substitution**
- a. The RCN recommends that further research on substitution should be undertaken to advance the knowledge on the economic value of nursing.
  - b. The RCN's key recommendation in terms of supporting cultural change is as follows:
    - Education** - Management training for nurses could include a component on how national policy is made and shaped through a programme similar to 'Westminster Explained'.
    - Transparent decision making** – More decision making needs to be shared and conducted in public.
    - Nursing leadership** - It is vital that the voice of nursing is adequately represented in the governance of the NHS at all levels.
- vii. **Nursing, personalisation and social care**
- a. Education, training, organisational and funding arrangements for nurses will need to change to ensure that there is sufficient capacity in the system to meet the demand and bring care 'closer to home' for patients<sup>6</sup>.
  - b. Continuity of care depends on effective relationships between professionals as well as clear communications with the patients receiving the care. Nurses will play a central by advocating patient centred care pathways and new business models designed around actual need and by co-ordinating the quality of the care episodes across boundaries.

<sup>4</sup> *Setting Appropriate Ward Staffing levels in NHS Acute Trusts*, RCN Policy Unit Guidance, September 2006

<sup>5</sup> Audit Commission, *Acute Hospital Portfolio - Ward Staffing*, 2001

<sup>6</sup> Sibbald, McDonald and Roland, *Shifting care from hospitals to the community: a review of the evidence of quality and efficiency*, Journal of Health Service Research and Policy, volume 12, page No 117-117 2007

- c. As far as the future for nursing is concerned, a shared vision and collective responsibility for creating a positive attitude to change is essential<sup>7</sup> to ensure personalisation is a success at all levels.
  - d. Outreach and tailored support will need to be available if personalised services are to be made available to the most excluded in society who are least well served by the NHS.
  - e. There is a need for a clear delineation between health and social care, including respective funding streams.
  - f. The RCN would support the introduction of an 'assigned nurse' to act as a link along the full length of the care pathway for those with long term conditions. They would co-ordinate the individual's overall case management and maintain an in depth knowledge of the patient's ongoing conditions (including clear information on self management and how to access service provision).
  - g. Nurse specialist posts for long-term conditions should continue to be developed and evaluated. Early evidence shows that early intervention by specialist nurses can prevent unnecessary admission to hospitals.
- viii. **Public health**
- a. In order to encourage innovative nursing practise in public health nurses should have support and access to training.
  - b. Measuring the socioeconomic benefit of public health practise involves considering health gain and also cost effectiveness. Public health nursing carries a short and long term benefit; many of the short term health gains such as reduced STI transmission are easily identifiable but the longer term benefits require more diligent and committed appraisal as they are not immediately identifiable (for e.g. a reduction in alcohol related liver disorders in old age)
  - c. An obstacle to realising these goals fully is the lack of research into the effectiveness of all areas of public health nursing. Most of the evidence base for effectiveness of public health nursing comes from areas of health promotion such as smoking cessation. More research needs to be conducted into public health practice effectiveness.

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<sup>7</sup> Manley, K., Sanders, K., Cardiff, S., Garbarino, L. and Davren, M (200 )'Effective Workplace Culture'