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.  

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 21st 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.

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 in 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 disenabling 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\(^2\), 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\(^3\) need to be implemented at the workplace level.

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\(^2\) 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)

\(^3\) 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\(^4\).

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\(^5\).

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\(^6\).

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.

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\(^4\) Setting Appropriate Ward Staffing levels in NHS Acute Trusts, RCN Policy Unit Guidance, September 2006

\(^5\) Audit Commission, Acute Hospital Portfolio - Ward Staffing, 2001

\(^6\) 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\(^7\) 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.

\(^7\) Manley, K., Sanders, K., Cardiff, S., Garbarino. L. and Davren, M (200 ) Effective Workplace Culture