Mid Staffordshire NHS Foundation Trust
Public Inquiry Report

Response of the
Royal College of Nursing
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The Royal College of Nursing (RCN) was saddened by the failures at Mid Staffordshire NHS Foundation Trust, which resulted in tragedy for so many patients and their families. The final report of the public inquiry into what happened at the trust marks a watershed in the history of our health service, and the detailed commentary diagnoses accurately the causes of the failures at Mid Staffordshire. In his covering letter to the Secretary of State for Health, Robert Francis QC said the story his report told was “first and foremost of appalling suffering of patients between 2005 and 2009”.

All professionals share responsibility for the failings. Appalling care cannot be tolerated and the RCN will do all it can to learn the lessons and help prevent similar care failings from happening again. As we have said on numerous occasions, the RCN will never be a refuge for poor care and we will do all we can to improve professional standards and expose the factors that contribute to unacceptable care.

While there can be no excuses for poor care, there are often explanations. Robert Francis identified a number of key areas that he believes require immediate attention if poor care is to be avoided in the future. He rightly identified the importance of culture, and the need to ensure that those at the top project the right priorities and put the patient above all else. The RCN believes that a toxic culture can pollute good people, and that when an organisation stretches its staff to the limit and demands that balance sheets matter more than patient care, standards will fall.

Robert Francis also highlighted key issues including the importance of safe staffing levels, the need for strong leadership at all levels of the NHS and the requirement for the full registration of health care support workers. His report must not go the way of so many other publications about the NHS, languishing on a shelf in a management office, unread and ignored. Instead, it must represent a trigger for action, where key recommendations are made a reality and patients are put at the heart of their care.

Although the RCN may offer alternatives to some of the 290 recommendations in his final report, we do fully back Robert Francis’ vision for an NHS in which the patient is at that heart of “everything that is done”.

Our response sets out what we believe needs to happen next and how we will contribute to fundamental change, both in the NHS and beyond.

Please note that throughout this document the term “health care support worker” includes health care assistants, assistant practitioners and unregistered staff working in support of registered nurses.
2. Executive summary

The Francis report, following the public inquiry into failings at Mid Staffordshire NHS Foundation Trust and those of regulatory bodies, represents a watershed moment in the history of our health service.

In this document, the RCN has sought to respond to many of Robert Francis’ 290 recommendations on what the NHS and the independent sector must do to ensure the failings at Mid Staffordshire are never repeated. We have sought to follow the same themes and structure that Robert Francis used in his seminal report, and have outlined our position on key recommendations, the work we have already undertaken and the important steps that need to be taken next.

Robert Francis discussed the role of the RCN in his report and highlighted that we could have done more locally to support our members on the ground. This is something that the RCN readily acknowledged in its initial response to the report (6 February 2013). Recommendation 201 of the Francis report suggests that the RCN should consider formally splitting its employee representation (trade union) function from the professional function. The RCN has discussed this with our membership on numerous occasions, most recently at RCN Congress in April 2013. At that meeting, 99 per cent of delegates expressed a wish to maintain the RCN’s current structure, and members repeatedly spoke of how they believed the relationship between our trade union and professional functions makes the RCN a stronger organisation. We believe, however, that there is more we can do to improve how these two sides interact and we will begin work in earnest to explore how to make this a reality.

The role of the named nurse and a move towards patient-centred care were both included in the Francis report. The RCN is not opposed to the named nurse idea, but the reality is that there are often too few nurses on the ground to make such a project work in reality. With appropriate staffing, however, the RCN would be supportive of such a move. As we explain in the relevant chapter, Robert Francis is right to demand a shift towards patient-centred care. The burden is now on NHS employers to give nursing staff the time, resources and support to deliver on this worthy ambition.

Robert Francis rightly demands a shift from task-focused care to patient-centred care, and the RCN agrees wholeheartedly. One main reason for a focus on putting the task before the patient has been the dilution of skill mix across the health service, with health care support workers being used to undertake the work of registered nurses.

One of the most significant themes in Robert Francis’ report is the impact of culture on the practice of organisations and staff. At Mid Staffordshire, there was an obvious disconnect, a gulf in communication between those on the trust board and those on the ward. A focus on unnecessary targets (often financial) meant that patients were sometimes not seen as the vulnerable human beings they are. Therefore we fully support Robert Francis’ recommendation for a shared culture in which “the patient is the priority in everything done”.

When a culture is not right in an organisation, it has an impact on the professional attitudes and behaviours of the staff who work for it. Put simply, a toxic culture can pollute good people. The RCN acknowledges that a very small but distinct minority of staff in the NHS exhibits attitudes and behaviours that are detrimental to patients. However, despite the rhetoric of some commentators, we do not believe that this is linked in any way to nursing students. On the contrary, poor behaviours and attitudes are often exhibited by staff who have worked in the NHS for decades. The RCN believes that the NHS often sets up good people to do bad things; through constant change, chronic under-staffing and unrelenting pressure, staff have kindness and compassion eroded from them. As we explain in this document, more must be done to tackle the burnout associated with the constant emotional labour of caring and to support staff who chose to give their working lives to our NHS.

Poor practice is not just about delivering poor care to patients; it is also about not doing enough to prevent poor care in the first place. Robert Francis recommended a new duty of candour that would oblige staff and employers to speak out when mistakes are made and which could have a negative effect on patients. He recommended that this duty should be legally enforceable and that criminal sanctions should apply to those who seek to obstruct staff in raising the alarm. The RCN supports many of the recommendations relating to the need for staff to speak out when they see poor care. However, we do not believe that there is a need for new criminal offences in relation to the statutory duty on individuals. We believe that a requirement to disclose information on acts or omissions in care is already provided by the Nursing and Midwifery Council code of conduct – part of a legal framework of accountability. Furthermore, we believe that such a move would be counter-productive to the ambition to improve openness and transparency in the NHS, and could in fact result in an even greater culture of fear.
The RCN does believe that all staff have a responsibility to raise concerns regarding poor care and the pressures that may eventually lead to poor care. We have recently revised key guidance for our members on the necessary steps they should take when they need to raise concerns.

One of the most debated recommendations in the Francis report relates to a proposal that would-be nurses should, for up to three months, work “on the direct care of patients under the supervision of a registered nurse”, the completion of which would be a precondition to the continuation of nurse training.

We firmly believe that the 2,300 hours that student nurses currently spend on clinical placements is sufficient preparation for the world of practice and patient care. Furthermore, there is no evidence that newly qualified nurses are exhibiting any behaviours that should give rise to the kind of concerns that would warrant such a radical change to the current system. The Willis Commission on the future of nursing education concluded that there were “no major shortcomings” in the way in which we train our nurses of the future – a view the RCN shares.

However, we understand that there may be room for improvement in nurse education. The RCN supports Robert Francis’ recommendation that we must recruit student nurses who exhibit the right values, display a desire to deliver compassionate care and learn the technical skills essential to modern-day nursing. Furthermore, we must continually evaluate the success of mentorship and preceptorship experiences, which are vital to the development of future nurses.

As Robert Francis rightly identifies, one of the most significant factors in the failings at Mid Staffordshire was a lack of leadership. This deficit applied to the board, middle management and to those leading wards. The RCN believes that nursing requires strong leadership in all echelons of the health service. We therefore support the recommendation for the continued role of the chief nursing officer. The RCN has long campaigned for nurses in positions of leadership, including the establishment of the director of nursing post. We therefore support the recommendation for increased opportunities for the multi-professional education of leaders, managers and indeed nurses. Importantly, the RCN supports Robert Francis’ emphasis on the role of the ward sister being crucial to the quality of the patient experience. The RCN has long called for the ward sister role to be given improved recognition and to be freed from clinical duties so that the individual can lead, teach and mentor staff.

In terms of the biggest priorities for the NHS in the next decade or so, few are more important than improving the quality of care delivered to older people. This group was let down badly at Mid Staffordshire, and we have seen similar instances of poor care in both NHS and independent care settings in recent years. The RCN believes that the whole care team has a role to play in delivering excellent care to older people. The delivery of good care to older people should not be viewed separately from the other challenges facing the NHS. Older people have significant care demands, but the current approach to staffing levels in this area is simply not recognising this. The RCN believes that mandatory safe staffing levels, the regulation of health care support workers and the delivery of consistent training will all lead to improvements in the care of older people.

The RCN believes that we need nationally recognised career pathways for those wishing to develop their skills in older people’s nursing at the post-registration stage, and that all those seeking to be a nurse understand how to deliver excellent care to older people.

It is not just the delivery of excellent frontline care that affects the patient experience; we know that the quality of record keeping, and how the information is then shared, matters too. The RCN broadly welcomes the recommendations made by Robert Francis and believes that the recent Caldicott review of information governance in health and social care offers excellent advice on how to improve the exchange of information between providers and their patients.

Of the numerous factors that lead to poor care, few are more important or powerful than unsafe staffing levels. Painting a stark picture, a recent report from the Centre for Workforce Intelligence highlighted that nurse numbers could fall by 11 per cent, or 63,800, in England by 2016 (CfWI, 2013).

The RCN’s own analysis, most notably through our Frontline First campaign, has shown continued cuts to nurse posts since 2010. Despite this, there is a wealth of evidence (highlighted below) that shows a link between the patient experience and the number of nursing staff on the ground.
2. Executive summary

The RCN believes that the time has come for health policy to address the importance of this relationship. The RCN supports Robert Francis’ recommendations around staffing levels, including metrics developed by the National Institute for Health and Care Excellence (NICE) and used by the Care Quality Commission (CQC), but we do not believe these measures go far enough. The RCN believes that the UK must follow the lead set by other countries, including Australia, and enshrine mandatory safe staffing levels in law. Establishing a range of such levels would be based on current evidence and patient dependency, and should be responsive to local need, but would offer the legal protection that patients deserve.

The RCN believes that this is one of the most important issues facing the NHS. Failure to tackle unsafe staffing would be to fail patients entirely.

Approximately a third of Robert Francis’ 290 recommendations relate to the regulation of the health care system. The RCN supports the use of expert inspectors, and urges the newly appointed chief inspector of hospitals to draw on existing clinical expertise within the CQC, specifically the national clinical advisers. The RCN supports proposals for a planned and incremental “merger of system regulatory functions between Monitor and the Care Quality Commission” (recommendation 64) but there are concerns about the increase in workload being demanded of both organisations. We believe there is a need for consolidation of the changes to both organisations that are already in progress. Both the CQC and Monitor will require new resources and skills to tackle the significant challenges that face them, and both would benefit from a greater degree of nursing input.

Robert Francis also made recommendations regarding the Nursing and Midwifery Council (NMC). In particular, he identified the largely reactive nature of the NMC’s work and proposed that, instead, the NMC should be able to launch proactive investigations if there is a concern regarding nursing fitness to practise. Although the RCN supports such a move in principle, it will only be possible through greater collaboration with health system regulators, notably by sharing information with the CQC.

In recent years, the NHS and the independent sector have become increasingly reliant on health care support workers (HCSWs). HCSWs are crucial to the delivery of patient care, but the problems that face this part of nursing must not be underestimated. Current training is inconsistent and HCSWs who are challenged for delivering poor patient care can simply move from one employer to another because of a lack of mandatory regulation. The RCN strongly supports Robert Francis’ recommendations on the role of HCSWs, particularly that of mandatory registration and eventual regulation. We know that hundreds of thousands of HCSWs are delivering essential care to patients, including many older people, and yet there is no central register of who they are, the training they have undertaken and where they have worked previously. The RCN believes this has to change. The mandatory regulation and training of the UK’s HCSWs is one of the most critical steps the Government can take to ensure the delivery of safe care to patients.

As can be seen in the pages of this document, the RCN has undertaken significant work already in the many areas identified by Robert Francis. As the professional voice for nursing, we do not underestimate the significant challenges that face all those who deliver care for patients, both directly and from management positions. This formal response is only one part of a broad spectrum of work that will be undertaken in the months and years to come.

Robert Francis has set out a clear direction for the future of the health service; the onus is now on all of us to make sure we follow it.

References


3. The RCN’s response to the key issues in the Francis report

3.1 The role of the RCN

Summary

The RCN acknowledges that it could and should have done more at Mid Staffordshire to support members on the ground. Since the events at Stafford Hospital were first reported, we have undertaken significant work to improve the support we provide our accredited representatives and active members, and to improve the way our members can raise concerns about standards of care.

We acknowledge Robert Francis’ recommendation (201) regarding a split of the RCN’s trade union and professional functions but, following detailed consideration and open conversation with our members, believe that we are stronger as one organisation.

On our dual role, we believe that the elements are complementary to one another and make us a stronger organisation. Trade union work is not simply consigned to fighting for better pay awards. Instead, it focuses on building a positive working environment for staff – and in health care that can have a direct impact on the quality of care delivered to patients.

However, that is not to say that the RCN is resistant to change. As is explained in this chapter, we plan to undertake a significant stream of activity in order to improve the work we deliver in all practice settings and bring the two aspects of our activity closer together. Similarly, we highlight where we need to better explain the distinction between these two roles and the instances in which they are rightly separate.
What did Robert Francis recommend?
In his report, Robert Francis recommended:

- **201**: The Royal College of Nursing should consider whether it should formally divide its “Royal College” functions and its employee representation/trade union functions between two bodies rather than behind internal “Chinese walls”.

What is the RCN’s position on the recommendations?
The RCN takes the criticism of its role in the events at Stafford Hospital very seriously. We have acknowledged that we should have done more locally to support our members on the ground and have sought to improve this representation following lessons learnt at Mid Staffordshire.

Although the RCN did raise a number of concerns at Mid Staffordshire, we fully accept that the professional nursing voice was not heard loudly enough. Modern nursing is a highly skilled profession working at the cutting edge of health science and has a direct impact on the quality of care patients receive. If the views of nursing leaders – whether managers, regulators, inspectors or RCN staff and representatives – are not listened to and taken seriously, patients will suffer.

The RCN accepts that we did not know enough about the clinical impact that changes at Mid Staffordshire were having on patients. Since the first inquiry in 2010, we have asked why this was and have reviewed the way we work at a local level to prevent this happening again.

Recommendation 201 of the report suggests that in order to “strengthen the nursing professional voice” the RCN should consider splitting our trade union and professional functions. We have given a lot of thought to the issues raised during the inquiry and have consulted our members.

In brief, the RCN exists to represent nurses and nursing, promote excellence in practice and shape health policies. The RCN’s role differs in a number of ways from those of the medical royal colleges. The RCN does not have powers to regulate nursing staff, inspect providers of care or enforce the clinical standards it develops. It is for that reason that developing our reputation as a professional body is so important. In practice this means we:

- lobby governments and others to develop and implement policy that improves the quality of patient care
- support nurses and nursing staff in all their diversity
- develop nurses professionally and academically, building our resource of professional expertise and leadership
- develop professional standards.

The RCN believes that the different elements of our organisation are complementary to one another and make us stronger. Trade union work is not simply consigned to fighting for better pay awards. Nor should we see professional standards of care as existing in isolation from how staff are treated in the workplace.

For example, there is a wealth of evidence that suggests unhealthy environments affect nurses’ physical and psychological health through the stress of heavy workloads, long hours, low professional status and difficult relations in the workplace. Long periods of stress can affect personal relationships and increase sick time, conflict, job dissatisfaction, turnover and inefficiency (Baumann et al., 2001).

In such situations, RCN workplace stewards and health and safety representatives may well raise concerns about terms and conditions of employment, as would be expected from a trade union. However, in the RCN, those activists are members of the nursing team and through the professional services of the RCN (such as our information and library services, standards team and nurse advisers) have access to a wealth of evidence about the impact such issues have on patient outcomes – for example, length of stay and safety. The RCN is clear that positive practice environments positively affect nursing and support high quality care. A workforce that feels valued, safe and healthy will deliver safer, more effective care.

However, we also know that adequate time is not always provided for local representatives to take part in strengthening the professional nursing voice. Recommendation 202 states that employers should ensure “adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard”. We endorse this recommendation and will be working with providers and commissioners to try to ensure that this is built into their workforce and financial planning.

The RCN is in a unique position to focus on building a positive working environment for staff in a way that can have a direct and positive impact on the quality of care delivered to patients. We strongly believe that our dual role as a professional body and union helps inform our work on a
great many issues, but where the situation calls for it, we
will strive to make absolutely clear the capacity in which
we are acting.

What has the RCN done already in this area?
The RCN has a long history of working with others to drive
up standards of care and of being an advocate for high
quality nursing care. The following information summarises
a number of partnerships the RCN has with other national
leaders in health and social care.

The RCN and the National Institute for Health and
Care Excellence
The RCN is a stakeholder in National Institute for
Health and Care Excellence (NICE) work programmes
covering health technology appraisal, public health
guidance, interventional procedures and national clinical
guidelines. As part of this process the RCN participates
in the development and review of draft guidance for
implementation in the NHS.

The RCN actively canvasses expert members who have
relevant expertise and are specialists in the topics under
review to contribute to the NICE work programme. RCN
members participate by reviewing draft consultation
documents or by applying to become members of the
guideline development groups.

The RCN and the Healthcare Quality Improvement Partnership
The Healthcare Quality Improvement Partnership (HQIP)
exists to promote quality in health and social care services
in the UK, and in particular to increase the impact of
clinical audit. We are proud to help lead the work of this
partnership as a member of the consortium along with the
Academy of Medical Royal Colleges and National Voices.
The main priority areas of concern for HQIP are:

- managing and improving the national clinical audit
  programme in England and Wales
- improving quality improvement expertise through
  training and resources
- building clinical audit and related programmes into
  commissioning, regulation and revalidation processes.

The RCN and the Academy of Medical Royal Colleges
The RCN is an active partner in the work of the academy and
supports other members in developing common standards
for patient care. For example, we have worked with
members of the academy to help reduce prescribing errors
by developing standards for the design of hospital inpatient
prescription charts.

The roles of the RCN
In addition to the above and since the first Mid Staffordshire
inquiry report was published, we have committed to
reviewing three main functions within the RCN – the role
of the RCN representative; supporting members in raising
concerns; and the role of the RCN in driving up standards
of care.

The role of the RCN representative
RCN representatives play a crucial role in the workplace,
challenging local decision making and raising members’
concerns for the benefit of patients and nursing staff.

The RCN supports recommendation 202 in the inquiry
report, which recognises the importance of the role and
asks that adequate time is given to perform it.

We recognise that there were too few stewards at Mid
Staffordshire when the care failings took place and that
they were not always adequately supported. The RCN has
therefore improved the way we support our representatives
throughout the UK.

We have transformed the mandatory learning and
development programme for our activists over the last
five years. The programme is externally accredited and is
now considered one of the best in the trade union sector.
In 2011, we started the rollout of mentorship and
supervision for all stewards by RCN staff to help support
them better. In 2012, we became one of the first unions to
introduce a full and bespoke case-management system,
creating a robust governance framework for stewards’ work.
This year we have started an investment programme for the
IT infrastructure used by our stewards for them to report
their casework.

Supporting members in raising concerns
In a time when large scale changes are being made in
the NHS, the RCN’s Frontline First initiative empowers
nursing staff to speak out against the cuts that impact on
patient care, expose where they see waste and highlight
innovations and new ideas (www.rcn.org.uk/frontlinefirst).

We have also revised and publicised our ‘whistleblowing’
guidance for members and have reviewed the way we
support them to raise concerns. We continue to develop
relationships with health regulators to share intelligence
about concerns over patient safety.
The role of the RCN in driving up standards
In response to the Francis report, the RCN has considered its dual role as a professional organisation and trade union. We have sought the views of our members, including holding dedicated events at RCN Congress over the last two years.

After looking at the range of professional support and resources we offer via staff, activists, professional networks and forums, and the success of the work we do in representing nurses and nursing, the RCN believes that the positives of our dual role far outweigh the negatives. The two aspects of the organisation are mutually reinforcing and complement each other for the benefit of our members, the nursing profession as a whole and patients. At RCN Congress 2013, 99 per cent of members voted in support of continuing the College’s joint trade union and professional body roles.

We will, however, take steps to clarify how the different parts of the organisation are connected and why. We will also review the scope of our professional activity to ensure that we are making clear what our priorities are and what we are doing about them.

Most recently, and since the publication of the Francis report, we have held workshops with our members to improve local discussion of professional issues. For example, in the West Midlands we have hosted local learning events that focus on issues including the raising of concerns, nurse leadership, accountability and delegation, pressure ulcer care and other clinical care subjects.

What does the RCN believe needs to happen next?
The RCN intends to undertake the following work around the area of its dual role. We will:

- convene a summit of key nursing and medical leaders to develop a co-ordinated action plan to address how we strengthen the professional voice of nursing
- develop and improve the role of the RCN accredited learning representative, using the knowledge that the RCN has from its dual functionality to enrich the work that these representatives undertake on the ground
- strengthen the work of the RCN’s Nursing Department, which exists to support the highest standards of patient-centred care through developing the evidence base for practice, setting standards for professional practice, and educating and empowering nurses and those who work with them to develop practice
- map and monitor executive nursing and other nurse leadership posts in all key health care organisations
- review our current approach to patient and public involvement in our standards development processes
- continue to develop relationships with the NHS across the UK as it changes and develops
- support nurse leaders and deliver tools and guidance to enable them to be the best they can
- continue to invest in joint work with the various royal colleges and professional bodies leading to common standards for care
- work with the NHS to make sure that recommendation 202 is fully implemented to ensure more people are able to provide professional leadership and support as RCN stewards, safety representatives and learning representatives.

References
3.2 Patient-centred care and the key nurse

Summary

Placing greater emphasis on patient-centred care was one of the most important themes within the inquiry report. Robert Francis made it clear that hearing and understanding patients must come first at all levels of the system.

The recommendations pointed to the importance of partnership between patients, their families and those delivering health care services. In particular, he recommends the introduction of a named key nurse system, where a patient would be given the name of the nurse responsible for their care.

The RCN agrees that a core priority should be to remove the barriers that get between nurses and their patients. We support the named key nurse role, as described by Francis, and suggest that they should be a registered nurse empowered and supported to be a positive focus for accountability, leadership and communication – not a blamed key nurse for when anything goes wrong.

The key nurse model could provide a useful way to organise work around the needs of the patient rather than around a series of tasks.

An essential foundation for successful and lasting implementation of the key nurse model will be ensuring that the right number of staff with the right skills are available on any given shift. Reduced staff numbers, an over-reliance on agency or bank staff and poor skill mix will conspire to reduce the effectiveness of this initiative.
What did Robert Francis recommend?
In his report, Robert Francis recommended:

• 199: Each patient should be allocated for each shift a named key nurse responsible for co-ordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient.

The report states that, under the direction of the ward leader, named key nurses need to take personal responsibility for and be committed to the care of their allocated patients. They need to act as the frontline faces to whom patients and those close to them feel comfortable to turn for help and information, and on whom ward managers are able to rely to co-ordinate the provision for each patient’s needs.

This function is imperative, particularly in the care of older patients and in managing and ensuring effective record-keeping processes in the absence of electronic systems.

What is the RCN’s position on the recommendation(s)?
The RCN is supportive of the concept of the key nurse. We believe that this particular recommendation aims to address a concern raised in the Francis Inquiry that some patients did not know who was in charge, who was co-ordinating their care, and who they could talk with in order to discuss changes to their care.

The key nurse recommendation reflects a core aim of named nursing which has been defined as coordinating the patient’s care and being in regular contact with the patient, who can therefore give informed consent to that care (Durgan, 1997). It can enhance transparency around decision making and provide a much clearer sense of accountability between the patient and the nursing team. However care must be taken around developing the model and implementing it in practice.

The named key nurse should be an empowered, supported and positive focus of accountability, leadership and communication – not a ‘blamed nurse’ for when anything goes wrong. This requires supportive management and effective supervision to help build staff and patient confidence in the model and address implementation issues promptly where they emerge.

The key nurse model could provide a useful way to organise work around the needs of the patient rather than around a series of tasks. The report ‘Delivering dignity’ by the NHS Confederation, Age UK and the Local Government Association, highlights this particularly clearly. It states:

“Alongside the consistent application of good practice and the rooting out of poor care, we need a major cultural shift in the way the system thinks about dignity, to ensure that care is person-centred and not task-focused.”

The patient and their family/carers should be able to expect to have regular and predictable contact with a lead registered nurse on each shift, and be able to engage fully in decisions about their care. Without this patient centred focus, the key nurse initiative will fail its most important test.

The RCN believes that the most effective way to organise named nursing will be for a registered nurse to be allocated on each shift. This addresses a common concern around some models of named nursing in which patients would ask for their named nurse only to find that their nurse is not at work because of leave or shift patterns.

There are a number of case studies in past literature which show that a named nurse approach can work in a number of care settings. However careful consideration needs to be given how the role complements that of other practitioners who may have key roles in the patient’s care pathway. It will be important not to harm existing therapeutic relationships by introducing an additional role that has not been properly defined or clarified for the health professional.

An essential foundation for successful and lasting implementation of the key nurse model will be ensuring that the right number of staff with the right skills are available on any given shift. Reduced staff numbers, an over-reliance on agency or bank staff and poor skill mix will conspire to reduce the effectiveness of this initiative.

What is the relevant evidence?
The concept of a named key nurse used by Robert Francis is not new, nor untested having been part of an established model for delivering community nursing, midwifery and health visiting in parts of the UK for some time (Hancock, 1992). Named nurse models have been linked to positive patient outcomes and staff satisfaction as well as empowering nurses and promoting autonomy (Duffield et al., 2010; Pearson et al., 2006). There is some indication that it may also reduce staff turnover (Butler et al., 2011) and workload (Aalto et al., 2009). The named nurse has
been shown to have crucial benefits under particular circumstances such as in children's services, including in supporting individuals during child protection cases (Rowse, 2009).

However, there is also evidence to suggest drawbacks in some named nurse models. In terms of patient satisfaction, there is little to suggest that these may be attributed to the operation of a particular model of care, but rather may be linked to operational conditions linked to those models. Conditions would include skill mix (number of registered nurses) and years of experience (Tervo-Heikkinen et al., 2008), or the perception of effective continuity and communication (Tiedman and Lookinland, 2004).

Organisational factors, such as intensity of unit operations and nursing resources, may hinder informational and emotional support for patients (Mattila et al., 2010). Named nursing may impede effective relationships with physicians (Sjetne et al., 2008) unless carefully implemented.

**What has the RCN done already in this area?**

The key nurse role as described by Francis has close alignment with many of the themes made explicit in the RCN principles of nursing practice, particularly nurses taking responsibility for patient-centred care, the role of the nurse as patient advocate and pivotal point of communication. As the principles of nursing practice are evidence-based and articulate a shared understanding of patients’ and nurses’ expectations of quality nursing care, such alignment reinforces the potential benefits of the primary nursing model for patients and nursing staff alike.

The concept of the key nurse has precedence in particular contexts of care delivery, such as nurses managing children with complex health needs or long-term conditions, psychiatric nurses with long-standing relationships with their clients, and specialist skills of learning disability nurses acting as a key nurse link and co-ordinator of care. The RCN produces standards and guidance to support best practice in these areas.

The RCN has initiatives focused on enabling the principles underlying the named nursing concept – specifically: accountability; responsibility; communication; and consistency. Joint work with the Royal College of Physicians (RCP) on best practice in ward rounds highlights the pivotal role of the nurse as a facilitator of communication for both patient and health care team, acting as a point of contact for patients and their families/carers, and ensuring that patient needs are identified and articulated across the health care team (RCP and RCN, 2012).

In developing a model of family-centred care for neonates, the RCN Research Institute found that for parents, their primary needs were communication, support and information (Staniszewska et al., 2012). While nurses have a key role in meeting these needs, the parent’s experience of care seems to focus on the various components of care rather than on which health care professional delivers it.

**What does the RCN believe needs to happen next?**

The RCN will support a well resourced, considered implementation plan for the key nurse role and will work with health and social care leaders to establish what action needs be taken to respond to the issues behind the recommendation.

Where indicated, the RCN will support the development of a national framework for a key nurse role that assists providers of care in a range of settings to adopt best practice. However, we believe that there are some care settings where this approach may be unhelpful and may exacerbate the issues that led Robert Francis to make the recommendation in the first place. Therefore careful implementation and evaluation from both staff and the patient’s perspective will be essential.

**References**


3. The RCN’s response to the key issues in the Francis Report


Hancock, C (1991) The named nurse concept Nursing Standard, 6 (17),16-18


3.3  A culture of care and safety

Summary

Robert Francis rightly identified that a culture of fear; disconnect between ward and board; and a focus on finances ahead of patients all contributed to the failings at Mid Staffordshire. The issue of culture is covered in significant detail within the report and the RCN supports Robert Francis’ vision to change the culture in the health service to one that focuses on the patient “in everything that is done”.

An organisation’s culture and the attitudes and behaviours of its staff are inextricably linked. While our response contains a separate chapter on attitudes and behaviour, it would be remiss not to highlight the connection. The RCN believes that a toxic culture can pollute good people, and that the priorities and behaviours of those at the top will eventually alter the actions of those work to deliver care in various practice settings.

Culture is an exceptionally wide, nebulous concept with a number of elements to it. In essence, “how we do things around here” is a powerful driver for staff behaviours and is directly related to the safety and effectiveness of care. How staff are rewarded or treated will invariably affect the culture within which care is delivered. If staff are told that the finances of an organisation are the priority, they are likely to adapt their attitudes and behaviour accordingly.

We therefore support Robert Francis’ recommendations concerning a common set of standards, enshrined in the NHS Constitution, which clearly seek to put the patient at the centre of the NHS.

We also support efforts to strengthen and support people in management and leadership roles so that initiatives which seek to build a safer, more caring culture are reinforced through effective decision making, role modelling and mentorship.
What did Robert Francis recommend?
The Francis report contains a number of references to the role of culture and its contribution to the failings within the Mid Staffordshire NHS Foundation Trust. It dedicates an entire chapter to discussing the issue (chapter 20) but addresses the components that drive culture in a number of places, in particular chapters 21 to 26. Chapter 20 specifically recommends:

- 2: The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires:
  - a common set of core values and standards shared throughout the system;
  - leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards;
  - a system which recognises and applies the values of transparency, honesty and candour;
  - freely available, useful, reliable and full information on attainment of the values and standards;
  - a tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.

- 11: Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the Trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.

For clarity’s sake, the Francis report defines culture (paragraph 20.5) in the context of health care as comprising:

- shared basic assumptions
- discovery, creation or development of those assumptions by a defined group
- group learning of how to cope with its problem of external adaptation and internal integration
- identification of ways that have worked well enough to be considered valid
- teaching new members of the group the correct way to perceive, think and feel in relation to any problems.

The report goes on to subdivide its discussion on organisational culture in health care as being concerned with safety and care, and says its intention is to describe a system that “aims to cause no harm to patients and to provide adequate and, where possible, excellent care and a common culture of caring, commitment and compassion”.

Having dealt with the existing NHS culture, underlying factors that influence culture and a discussion on possible approaches towards changing culture, the report goes on to illustrate what a common culture would look like. It is this section of chapter 20 and the assumptions preceding it which forms the basis for the main recommendations on culture.

What is the RCN’s position on the recommendations?
The RCN fully supports the recommendation that “the NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done”. Furthermore, we believe that recommendations five and eight are an important step forward in providing a framework for the development of a common NHS culture. The RCN supports clear expectations in the NHS Constitution that staff put patients before themselves and will do everything in their power to protect patients from avoidable harm; be honest and open with patients regardless of the consequences for themselves; that all contractors providing outsourced services to the NHS should also be required to abide by these requirements; and that staff employed by them for these purposes do so as well.

We also support the main thrust of recommendation 11 in that we agree there needs to be joint work on developing and maintaining effective procedures for delivering high-quality, patient-centred services. Where such procedures fail, we fully expect all staff to work together to learn lessons and adjust ways of working. This will require investment in people in management and leadership roles so that they can be both visible and credible. Initiatives which seek to build a safer, more caring culture are reinforced through effective decision making, high visibility role modelling and effective mentorship of future leaders.

We agree with Francis that “a shared positive safety culture requires: shared values in which the patient is the priority of everything done; zero tolerance of substandard care; empowering frontline staff with the responsibility and freedom to deliver safe care; recognising them for their contribution; and that professional responsibility is accepted and pursued”.

3. The RCN’s response to the key issues in the Francis Report
Furthermore, we agree that leaders of organisations “must not only require others to adopt the shared culture, they must do so themselves and be seen to do so”. This involves measures such as open board meetings, personally listening to complaints, and an open and honest admission where there is an inability to offer a service. At a system level it has to be shown constantly how the wellbeing of patients is protected or improved by measures proposed.

We firmly support recommendation 59 that there should be a category of board representative for the professions, a representative of nursing and allied health care professionals, and patient representative groups. We believe that this initiative would be strengthened by reviewing the role of governors in Foundation Trusts (particularly staff governors) and seeking to strengthen the role they play in decision making.

There are a number of national and international examples that point to the benefits of adopting this recommendation and increasing patient and staff voice at board level. For example, in NHS Scotland, through the local partnership infrastructure, a trade union representative is elected to represent the combined trade unions as the employee director. This post functions as a non-executive member of the NHS board; the position is full time and fully funded by the NHS board. In Norway, hospital board meetings are open to employees and the public. Furthermore, a trade union representative sits on the board of the health trust or hospital and has equal say in all board decisions. This person presents concerns raised by staff and is also involved in the complaint-handling process at board level.

We also support and will work to develop clarification of expectations and behaviours outlined by both Robert Francis and in the Government’s response with regards to openness, transparency and honesty as essential features of a caring culture.

The RCN is aware that the Government has introduced the role of a chief inspector of hospitals. The Government proposes that the post-holder will make assessments of the culture of institutions and how it is influenced by complaints, whistleblowing, patient experience, staffing levels and staff experience. We believe this could be an important step towards addressing the current imbalance which in the past has suggested that financial measures have more authority than those that focus on quality, experience and care. Boards need to be clear on the standards that are core to the business of providing safe and effective care and should be able to make brave decisions in response to feedback and not just slavishly focus on targets.

It is essential to redress this balance as part of creating the right culture within the NHS and among contractors who carry out work on behalf of the NHS.

**What is the relevant evidence?**

Cultures can be described as “ways of thinking, behaving and believing” that people hold in common. They can be influenced by organisational values, practice environments, the physical environment, learning environments and person-centred assessments (Strachan, 2009).

No single change in policy or practice can reasonably be expected to change organisational culture, particularly in an organisation as complex and diverse as the NHS. Changes in organisational culture are influenced by issues such as employer attitudes and behaviours; staffing and skill mix; internal processes such as teamwork; safety systems and supervision (Boorman, 2009); integration with other services (such as social care); and particular patterns of behaviour and socialisation.

We are particularly aware of the role of leadership in developing teams that work together to create the right culture of care and safety. Leaders who learn, are consistent, demonstrate care of staff and work to unite others around a small number of common objectives can have a dramatic effect on staff behaviours (King’s Fund, 2013). Work by West and Lyubovnikova suggested that real team working (where staff value each other’s contributions, are clear about their objectives and meet together to review performance against those objectives) is associated with higher quality, safer working. The absence of common goals – “pseudo team working” – is associated with harm for both staff and patients (West and Lyubovnikova, 2012).

Any or all of these issues can positively or negatively affect the quality of care and how staff achieve organisational goals (Plesk, 2001). Simply tackling one without addressing the other is unlikely to achieve lasting change.

**Creating a culture of safety**

Understanding how a culture of safety influences behaviour has arisen out of research into high-reliability organisations working in the aviation and oil and gas industries. The changes in the safety culture prevalent in both industries took decades to evolve. Despite the apparent differences between those industries and health care, the lesson from both industries is that safety management systems cannot
be imposed mechanically in isolation – they require a culture of safety for them be effective (Hudson, 2003).

Models of cultural maturity have been proposed (Westrum, 1991) that show how safety cultures can be categorised according to key attributes. The least mature is the pathological where safety is considered to be a problem caused by employees. Its main drivers are financial and a determination not to get ‘caught’ by the regulator.

At the other extreme is a generative culture where there is active participation at all levels. All activity has safety as a central concern and there is a constant effort to improve operations. It is this generative culture that the NHS must aspire to and avoid seeking individuals to blame for what are often system failures.

Creating a culture of care
There is a wealth of international evidence concerning care, the factors that influence the experience and delivery of care and what can be done to enhance it. Among the many studies, there is some consensus on a number of issues that must be tackled together in order to develop and sustain a culture of care.

The following variables have been found to influence caring behaviours in a meta synthesis of 49 qualitative reports and six concept analyses of (nurse) caring (Finfgeld-Connette, 2008):

• “care recipients”: this includes the patient or service user’s need for caring and their openness to being cared for (it has been suggested that caring is difficult if patients are not consciously aware or are unable to engage with care through, for example, problems of capacity such as dementia)
• “nurses’ professional maturity and moral foundations”: this includes the nurse’s knowledge base, competencies and the capacity to cope with the care challenges
• “a conducive work environment”: there is evidence to suggest that caring must be cultivated via training, development and role modelling. Work environments must be conducive to caring, with adequate resources and time to carry out caring. Nurses must also experience care from employers and others through being recognised for accomplishments and supported by team members.

The National Centre for Compassionate Caring in New Zealand has identified both organisational and individual factors to improve health care experience. These include: declaring compassion as a core value; management and leadership competence; rewarding compassionate caring; improving communication and relationship skills; supporting staff in discussing difficult issues; challenging models of professionalism; hardwiring new behaviours; and engaging consumers in change (NHS Confederation, 2008).

There are also a number of authors who suggest that staff deployment and skill mix impact on effective team working and a range of non-clinical outcomes such as the experience of care (Aiken et al., 2002; Boorman, 2009). Linked to deployment and skill mix, staff professionalism and self-resilience can provide a moral foundation for behaviours and individual accountability. Strategies that support self-resilience include supporting staff to balance work, life and “time for self-renewal” (Turkel and Ray, 2004).

What has the RCN done already in this area?
The RCN works to support a generative, evidential approach to creating the right culture of care and safety, and has made a significant contribution towards improving patient dignity and patient safety in a number of areas, often working closely with other royal colleges and patient groups.

For example, high profile RCN work on Dementia (jointly funded by the Department of Health and the RCN Foundation), dignity in care and nutrition have all played a role in driving up standards of care in practice by putting evidence based, effective tools in the hands of nursing teams.

Ward handovers have been identified as a communication hotspot where misinformation, missing information or untimely information contribute to a significant number of patient safety incidents and workflow problems (BMA, 2004). Effective communication is identified as one of the key RCN principles of nursing practice (Casey and Wallis, 2011).

The RCN principles of nursing practice describe what the public can expect from nursing practice in any setting. They have been produced jointly between nurses and patient groups. The principles were drawn up as there was no existing publication that explained what nurses and nursing staff do. They are intended for nursing teams for the purposes of quality improvement and continuing professional development, and for sharing with patients and carers. They enable anyone to know what quality nursing looks like. Principles A, D E and H are particularly pertinent to developing a positive organisational culture.
Furthermore, our contributions to national work on venous thromboemboli, which account for one in 10 deaths in hospital (Lifeblood, 2012), has been recognised by the Department of Health (Keogh, 2010).

In addition to the work set out above, the independent Willis Commission on the future of nurse education (The Willis Commission, 2012) recommended that the culture of health care provider organisations should routinely be assessed, building on ongoing work to develop and standardise a “cultural barometer” that will help their boards ensure that practice settings are suitable learning environments. This is to support the development of clinical placements that ensure nursing students are ‘socialised’ into an appropriate climate of care and compassion as they prepare to work as registered nurses.

What does the RCN believe needs to happen next?
Staff at all levels need to be supported and encouraged to explore the prevailing culture and enabled to contribute effectively to the development and maintenance of the open, positive culture envisaged in the Francis report.

The RCN has already published a clear set of principles of nursing practice and will continue to promote the use of these to help nurses explore and reflect on the quality of their practice and the factors, including culture, that can affect it.

The RCN is actively contributing to the development of the fundamental standards for organisations as proposed in the inquiry’s recommendations.

We note the proposed development of a “cultural barometer” and await with interest the outcome of the work being undertaken on this topic by the National Nursing Research Unit, King’s College London (King’s Fund, 2013).

The RCN will work with other leadership and patient organisations to develop a range of initiatives to support providers in building a common culture of care.

References


3.4 A culture of transparency, openness and the duty of candour

Summary

The RCN believes that large parts of the NHS need to change fundamentally the way in which patient feedback and complaints are viewed and used. Much more importance needs to be attributed to the ongoing experience of patient care and how that can be used to identify systemic as well as individual concerns.

In that sense, future work needs to focus on developing competence in and understanding of the continuum of information from informal satisfaction ratings, through structured gathering of experiential data, right up to the appropriate escalation of serious concerns via formal complaints and ‘whistle blowing’.

Instead of complaints being seen as interruptions in the delivery of care, or worse simply being treated as a possible legal problem, the NHS must be positive about getting and using patient feedback. There needs to be organisational time and energy to allow focus on the content of feedback, not just the amount given.

We are supportive of a number of recommendations relating to the creation of an environment in which complaints and ongoing patient feedback are seen as essential tools for driving up standards.

The RCN understands the issues that lie behind a recommendation for a new statutory duty of candour for registered medical practitioners, nurses and other professionals. However; we suggest that there is already a range of existing obligations and remedies available that may make additional legal duties unwarranted.
What did Robert Francis recommend?

There are a number of sections in the Francis report that deal with openness to feedback complaints and sharing information candidly to assist in driving up standards of care. The relevant recommendations are summarised below.

- **12:** Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.

- **38:** The Care Quality Commission (CQC) should ensure that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out. Any bureaucratic or legal obstacles to this should be removed.

- **39:** The CQC should introduce a mandated return for providers about patterns of complaints, how they were dealt with, and the outcomes.

- **40:** It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.

- **109:** Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider Trust.

- **181:** A statutory obligation should be imposed to observe a duty of candour:
  - On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request;
  - On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable. The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.

- **178:** The NHS Constitution should be revised to include references to openness, transparency and the duty of candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with these principles and recommendations.

- **255:** Using patient feedback: results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near “real time” as possible, even if later adjustments have to be made.

The Francis report in general calls for greater openness, transparency and candour in health care. The term “openness, transparency and candour” is wide-ranging in the report, and is applied to everything from informal feedback from patients and their families up to and including whistleblowing.

The report is clear that the delivery of feedback should involve offering a “balanced picture of performance generally that is devoid of the ‘spin’ of downgrading important matters of concern and exaggerating positive achievements”. It is worth quoting Robert Francis in full:

“It requires insight into personal and organisational deficiencies and the welcoming of constructive criticism. Above all, it requires a determination to put right what has gone wrong, not only for any who have suffered as a result, but to protect future patients from a repetition of wrong-doing. It requires a willingness to learn and be challenged.”

Firstly, Francis rightly highlights (paragraph 26.190) that “effective patient feedback is a powerful means of scrutinising the performance of providers in terms of safety and quality”. Obtaining feedback from patients and others during the course of their care has its own value – it can demonstrate a willingness by a provider to discuss matters that are worrying patients and their families, and convey genuine concern and care. However, it is also clear that some may feel unable to give full and frank feedback while receiving care for fear of repercussions.

There are also a number of different gateways through which patient and public comments can be made. Because of this, Francis suggests some form of consistency across the country in terms of methods of access and publication.
of outputs in order to facilitate “fair and informed comparison between organisations”.

Secondly, candour is defined as “the volunteering of all relevant information to persons who have, or may have, been harmed by the provision of services, whether or not the information has been requested, and whether or not a complaint or a report about that provision has been made”.

There are 13 recommendations (173 to 184, and 273) that should be seen as having a common purpose: to seek to provide a greater emphasis on sharing information as a matter of routine and as part of creating an effective patient-centred culture.

**What is the RCN’s position on the recommendations?**

We are supportive of a number of recommendations relating to the creation of an environment in which learning from complaints and ongoing patient feedback are seen as essential tools for driving up standards.

In particular we support recommendations 254 to 256, which capture some of the steps that need to be taken to make more of “real time” feedback from patients about the experience of care. It is also important that staff receive feedback from their employer when they raise concerns – something addressed by recommendation 12 and which we support.

The RCN believes that there needs to be a fundamental shift in attitude towards feedback, so that health professionals, managers and trust boards see it more as an opportunity to drive improvement rather than something to be managed at arm’s length to avoid the risk of litigation. As such recommendations 174 to 180 are accepted by the RCN, along with recommendation 273.

In terms of recommendations 181 to 184 (about a statutory duty of candour, new criminal offences and measures to enforce the above), the RCN accepts that trust and respect between health professionals and their patients is rooted in a culture of openness and honesty – a reasonable expectation of all health care environments.

This general principle should extend to informing patients about actions that have resulted in harm. The Francis report describes many of the guidelines and policy statements of bodies such as the Department of Health, the National Patient Safety Agency, the Care Quality Commission and the NHS Litigation Authority, about an expectation of disclosure, which of course is also enshrined in the NHS Constitution. The RCN agrees that, in addition to being a widely accepted ethical principle, disclosure of errors is likely to assist the learning that lies at the heart of improving patient safety.

The Francis report also acknowledges that the ethical obligation of disclosure is a requirement of the professional practice codes of both the Nursing and Midwifery Council (NMC) and the General Medical Council. A breach of the relevant code is a significant matter for any health professional, carrying the ultimate sanction of striking off – that is, being forbidden to practise. Hence, it is taken very seriously by all NMC registrants.

However, the RCN recognises that, notwithstanding those codes, informing patients about adverse events is not as widespread as it should be, though there is a complex range of factors that may explain this. These include a fear of litigation (notwithstanding the provisions of the Compensation Act 2006, which give an assurance that an apology or offer of redress is not the same as an admission of liability), or perhaps of disciplinary action; an absence of relevant communication skills in conveying sensitive information of this nature to a patient; and, in particular, a culture within the employing organisation that militates against such disclosures.

In summary, the RCN understands the issues that lie behind a recommendation that a new statutory duty of candour be imposed on registered medical practitioners, nurses and other professionals to report to their employer where they believe or suspect that treatment or care provided to a patient has caused death or serious injury (recommendation 181). There might be an argument to apply such duties to organisations. However, we suggest that there are already a range of existing obligations and remedies available that may make additional legal duties unwarranted. For example, the requirement to volunteer information to patients when harm has been caused is contained in the relevant professional code of practice. It is for this reason that we support the introduction of national registration and then regulation of HCSWs which we cover in more detail in a later chapter.

There are opportunities to explore what steps the relevant regulatory bodies can take to support disclosure, and review the requirements of the codes to ensure greater consistency and clarity of objective. We recommend that the code of conduct for NHS managers should contain a similar requirement to that imposed on professional registrants.
As such the RCN also has concerns about the proposed new criminal offences in relation to the above statutory duty (recommendation 183). The Francis report states that, for example, unintentionally misleading assertions, information or statements by the trust arose through carelessness rather than dishonesty, reflecting a “natural human reaction to potential criticism, and an institutional will to put the best gloss on performance” (paragraph 22.155). Therefore the evidence, in our view, does not support the further criminalisation of health care delivery, and we doubt it would encourage greater openness and transparency by health professionals. Rather, it may lead to the development of a culture of fear that discourages openness and transparency.

All the above recommendations that we support should be seen as being interdependent on each other to some degree and will require a concerted effort over time, not only to develop the national standards for handling this important information, but also to invest in the education and development of staff. In that sense, they are about creating the right culture. It will therefore be essential for staff at every level to exhibit the behaviours required to convey a sincere interest in feedback from patients and their families, no matter how hard it is to hear. We support an active role for the chief executive and non-executive directors in personally hearing feedback and complaints from patients and their families.

Effective public protection depends on learning from mistakes. Disciplining nurses in response to human error does not improve public safety, though nurses who make reckless choices must be held accountable (Burhans et al., 2012). A balance must be struck between establishing systems of organisational responsibility while at the same time maintaining professional accountability (Australian Council for Safety and Quality, 2003).

There is limited international evidence that in situations where all staff have a legal duty to report poor care or unprofessional behaviour through the available reporting structures that a more open and transparent culture results, particularly around whistleblowing (Lewis and Trygstad, 2009).

There is evidence that staff stop sending in reports or concerns when there is no feedback from their employer or when they receive negative feedback for making a report. A survey undertaken for RCN Congress 2013 found that 64 per cent of the 8,262 nurse respondents had raised a concern, mostly about unsafe staffing or patient safety. But 24 per cent said they were discouraged or warned off taking any further action by managers or colleagues. Any feedback given can provide positive or negative reinforcement for staff that their views and the views of their patients are important and can make a difference.

There are examples of electronic complaint handling systems in Europe where all concerns raised are assigned a level of priority with red level high-priority cases being reported to national regulators within 24 hours (Lewis and Trygstad, 2009). In that way, patient feedback is tied directly to providers’ conditions of operation.

We have found that nursing staff tend to view whistleblowing as a high-risk, low-benefit action (Attree, 2007). Nurses blow the whistle as a last resort in their role as advocates for patients and promoters of patient safety (Jackson et al., 2010). Descriptions of the experiences of nurse whistleblowers show that whistleblowing is a stigmatised activity carried out at considerable personal expense to the individual (Peters et al., 2011) and with negative ramifications for the organisation (Jackson et al., 2010).

There are a number of excellent resources available to organisations seeking to create a culture of open disclosure. In research terms, the aims of building such a culture are frequently tied to a need to avoid litigation costs and other business reasons (Fallowfield and Jenkins, 2004).
However, working towards an open-disclosure culture can strengthen staff-patient relationships, promote trust and provide a more sustainable improvement in care quality over time. It can also help foster a sense of patient autonomy.

The RCN believes that greater organisational encouragement of openness about safety, a reinforced professional obligation and better training in communication skills are just as likely to change current behaviours as the introduction of a new statutory requirement. The appropriate enforcement of which, and any available sanctions, are currently unclear.

**What has the RCN done already in this area?**
The RCN has undertaken a number of activities that have worked together to support an open, disclosing culture where complaints are seen as an essential part of driving improvements in care.

**Feedback and complaints**
As part of our commitment to improving how the NHS handles feedback and complaints, we have contributed towards the NHS complaints system review being led by Ann Clwyd, MP for Cynon Valley, and Professor Tricia Hart, Chief Executive of South Tees Hospitals NHS Foundation Trust and adviser to Robert Francis during his two inquiries into Mid Staffordshire NHS Trust. It is important that we deliver an approach which can focus both on the number of complaints and the content of complaints – both perspectives can be valuable indicators of systemic and ongoing concerns.

We have developed the RCN principles of nursing practice, two of which relate to transparency, openness and complaints:

- principle D: nurses and nursing staff provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care
- principle E: nurses and nursing staff are at the heart of the communication process. They assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.

**Raising concerns, raising standards**
After the concerns of staff at Mid Staffordshire NHS Foundation Trust first came to light, the RCN launched a dedicated telephone line in 2009, to allow RCN members to talk in confidence about serious and immediate worries that patient safety was being put at risk in their workplace. This information is used to support the nurse to raise concerns and, if needed, the RCN steps in to raise those concerns directly with employers. RCN members can also report their concerns using a form on the RCN website.

The telephone line and online form were launched at the same time a survey of over 5,000 RCN members showed that nearly two-thirds of nurses had raised concerns about patient safety with their employers and more than one in three of those said no action was taken.

In March 2013, the RCN also produced new, updated guidance about how to raise concerns. There are resources for both members and accredited representatives available on the RCN’s website.

**What does the RCN believe needs to happen next?**
The RCN will work with patient groups and executive nurses to develop standards and resources to support their work in leading a change in the way that boards and staff view patient feedback and complaints.

The RCN will continue to lobby governments and work with NHS England to ensure that adequate resources are available to service providers to support investment in staff education and in developing infrastructure to support reporting. The RCN believes that commissioners are partners in this process and should build in patient feedback and complaints data as part of their contractual performance-monitoring processes.

RCN advice to members is to deal with a concern early rather than let it become a bigger problem. RCN senior managers, officers and advisers have been advised similarly and are working to deliver clear alert processes to escalate concerns appropriately wherever they are raised within the organisation.

We will continue our work with regulators and others to clarify the role of the RCN as a vehicle for staff raising concerns.
References


3.5 Professional attitudes and behaviours

Summary

Attitudes and behaviours of staff should not be seen in isolation. While there are clear cases of poor conduct for which individuals must be held to account, attitudes and behaviours of staff are often shaped by the system around them.

Although attitudes reflect the values nurses may hold, their behaviours are the things they do or say, and are the things that patients experience. Therefore, behaviour may be affected by factors other than attitudes of the individual, in particular the working environment and organisational cultures.

As we outline in this chapter, the assessment of appropriate values in recruitment processes is sensible and should cover all NHS staff regardless of whether the post in question has a frontline care-delivery function. The RCN has examples of its own set of nursing values, the principles of nursing practice, being used as a framework for recruitment.

Enabling and demonstrating professional attitudes and behaviours are collective responsibilities that range from development and implementation of government policy and professional standards, through to the actions of boards, ward leaders and individuals.
What did Robert Francis recommend?

In his report, Robert Francis recommended:

- **185:** There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires:
  - Selection of recruits to the profession who evidence the:
    - Possession of the appropriate values, attitudes and behaviours;
    - Ability and motivation to enable them to put the welfare of others above their own interests;
    - Drive to maintain, develop and improve their own standards and abilities;
    - Intellectual achievements to enable them to acquire through training the necessary technical skills;
  - Training and experience in delivery of compassionate care;
  - Leadership which constantly reinforces values and standards of compassionate care;
  - Involvement in, and responsibility for, the planning and delivery of compassionate care;
  - Constant support and incentivisation which values nurses and the work they do through:
    - Recognition of achievement;
    - Regular, comprehensive feedback on performance and concerns;
    - Encouraging them to report concerns and to give priority to patient well-being.

- **188:** The Nursing and Midwifery Council, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates’ attitudes towards caring, compassion and other necessary professional values.

- **191:** Health care employers recruiting nursing staff, whether qualified or unqualified, should assess candidates’ values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.

Individual behaviour is firmly set within organisational context, hence the key themes of culture, leadership and shared core values. A declining professionalism and tolerance of poor standards are noted by Robert Francis as being brought about by poor leadership and by policies that have resulted in inadequate staffing levels.

A series of recommendations directly addresses professional nurse attitudes and behaviours (although many of the lessons learnt from the inquiry relate to all staff working in the NHS). The context of these recommendations was the proposal that recruitment should have a focus on candidates’ having “appropriate values, attitudes and behaviours” (recommendation 185), through a form of assessment for all nursing staff (191), particularly an aptitude test for aspirant registered nurses (188).

What is the RCN’s position on the recommendations?

The recommendations to embed assessment of appropriate values in recruitment processes are sensible and should cover all NHS staff, regardless of whether the post in question has a frontline care delivery function. The RCN has examples of its own set of nursing values, the principles of nursing practice, being used as a framework for recruitment (RCN, 2013a).

When considering issues of professional attitudes and behaviours, it is important to be clear on what exactly is being addressed. One simple approach is that attitudes reflect the values nurses may hold, their thoughts and feelings about things. Behaviours are the things that nurses do or say and, it could be argued, are what patients experience. The operational, day-to-day experience is more complex, as behaviour may be affected by factors other than the attitudes an individual may hold, not least a working environment that is unduly pressured or in some way dysfunctional. It is the ability of staff to present professional attitudes and behaviours that is important. The combination of an individual’s professionalism together with a healthy working environment can enable professional attitudes and behaviours to flourish.

Organisational culture, which is discussed in a separate chapter, is one such enabler. However, culture is not an entity in and of itself, functioning independently of the values and attitudes of individuals making up an organisation (Bandura, 2000). Rather, it is a product of each of those individuals and the factors that influence them. Enabling and demonstrating professional attitudes and behaviours is a collective responsibility that ranges from development and implementation of government policy and professional standards, through to the actions of boards, ward leaders and individuals.

The RCN believes that some nursing staff, particularly those who have worked in the system for a number of decades, eventually suffer from “care fatigue”. They joined
the profession intent on delivering good care, but years of a pressurised, constantly changing system in which their concerns are repeatedly ignored effectively grinds the compassion out of them.

The RCN does not believe (nor is there any evidence to support) that nursing staff begin a shift intent on delivering sub-standard care. Instead, a combination of factors can, over time, erode resilience, distort values and stretch them to their limits. It is then that otherwise good people can engage in “bad” attitudes and behaviours. This is discussed further below.

What is the relevant evidence?
Addressing issues of professional attitudes and behaviours is a key element of the RCN’s This is nursing work (RCN, 2013b). We have looked at the component influences and drivers that affect nurse attitudes and behaviours (Scrivener and Watts, 2013), and explored where best practice can be determined from the available evidence base. To a large extent, these components are tackled in more detail elsewhere in this document, and reflect many of the elements of the Francis report recommendations in chapter 23: collective values; supportive leadership; a culture of open and truthful addressing of incidents or problems; education and training in delivering compassionate care.

One focus for our work has been around how nurses are best socialised into the profession, whether that be in the transition from student to nurse, across differing roles and workplaces or in conjunction with multi-professional teams. A companion to this was our work investigating research around mentoring and preceptorship for the Willis Commission on the future of nursing education (Willis Commission, 2012).

Professional socialisation is the process by which nurses acquire skills, knowledge and identity characteristics of the profession, and internalise the values and norms of the working environment that they are socialised into (Curtis et al., 2012).

Being socialised into an environment in a negative way may have damaging consequences, bringing about a lack of critical awareness of practice, continuance of ritualised practice and a loss of idealism (Mackintosh, 2010; Chan and Chan, 2008), all of which may have a direct impact on the ability to care.

Socialisation is supported by effective leadership and role-modelling from leaders with clearly defined roles, as well as the quality of the educational environment (RCN, 2009; Sawbridge and Hewison, 2010). However, despite recognition of the significance of transitions in nursing education and from newly registered nurse to effective practitioner (Department of Health, 2009, 2010; NHS Education Scotland, 2011) there is a lack of evidence about successful implementation of strategies involving mentorship and preceptorship (Morgan et al., 2012; National Nursing Research Unit, 2009).

Research involving newly qualified nurses has suggested that the experience of socialisation, in moving from education to beginning a professional career, may have an impact on the adoption and manifestation of professional attitudes and behaviours as nurses are assimilated into local teams (Watterson and Smith, 2013).

There is an emerging picture which suggests that the attitude of an organisation to its staff is of equal importance as the attitude of staff to patients. This attitude may be felt most keenly during the socialisation experience. There are strong links between how staff perceive the fairness of their working environment and how they comply with organisational goals (Greenberg, 2011), the latter of which might include shared values.

A sense of achievement and effectiveness, termed “collective efficacy”, motivates people to perform better and overcome setbacks (Bandura, 2000). Staff who are motivated and feel that they are fairly treated have an increased sense of wellbeing, which itself has been shown to have a beneficial relationship to patient-reported experience (Maben et al., 2012).

What has the RCN done already in this area?
The RCN has a role in establishing, leading and promoting professionalism in nursing. As well as the research outlined above, key in addressing professional attitudes and behaviours are the principles of nursing practice (RCN, 2013c), which were developed in partnership with patients, the public and health care professionals. Their strength within the context of upholding professional attitudes and behaviours is that they can set both individual and organisational values. The RCN Principles at work project identified ways to support nurses generally, specifically members and accredited representatives, to promote the principles of nursing practice and use them to identify good practice, as well as describe and raise concerns. This project saw the principles discussed at regional workshops and our members actively involved in delivering them in their places of work.
The RCN has undertaken research to hear and understand the patient experience of nurse attitudes and behaviours reported through online reporting mechanisms. Analysing data from the Patient Opinion website, we have charted the most frequent descriptions of patient-reported experience of nurse attitudes or behaviours.

What does the RCN believe needs to happen next?
As part of its This is nursing initiative, the RCN has a work-stream of activity focusing on the importance of attitudes and behaviours. This work continues in earnest and will deliver analysis of the factors that can influence attitudes and behaviours, and recommendations around how these can be addressed.

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3.6 Education and development

Summary

The RCN believes that nursing students bring enthusiasm, compassion and skills to the wards and communities in which they work.

However, we accept there is always room for improvement, and it is for this reason that we support some of Robert Francis’ recommendations in this area. As can be seen from this chapter, we support moves to introduce values-based recruitment, and a consistent UK-wide framework for the education and training of our nurses of the future.

The RCN does not believe that there is wide enough recognition of the fact that a student nurse will spend 2,300 hours during their undergraduate programme in hands-on practice settings. The recommendation that “there should be a national entry-level requirement that nursing students spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse” needs to be considered alongside the fact that practical experience is already on offer throughout UK pre-registration programmes of education.

These programmes involve direct care of patients, including older people, and substantial hands-on physical care. There are also a number of checks in place to ensure that satisfactory completion of this direct-care experience is a determining factor in being allowed to continue on the course.

However, we do believe that once newly registered there is a need for more structured support and consolidation of learning. The RCN and many others have called for a strengthening of that important “preceptorship” first year of registration.

The RCN, along with others, has previously stated that continuing professional development is “fundamental to the development of all health and social care practitioners, and is the mechanism through which high quality patient and client care is identified, maintained and developed” (RCN et al., 2007). Patients and their families have a right to access health and social care practitioners who possess up-to-date knowledge, skills and abilities appropriate to their sphere of practice.
3. The RCN’s response to the key issues in the Francis Report

What did Robert Francis recommend?
In his report, Robert Francis recommended:

- **186**: Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all trainees throughout the country. This requires national standards.

- **187**: There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.

- **189**: The NMC and other professional and academic bodies should work towards a common qualification assessment/examination.

The Francis inquiry rightly identifies high-quality education as a significant driver for improving the culture of the NHS.

This response deals solely with the recommendations targeted at nurses and nursing. In particular, Francis suggests (recommendation 185) that a system that delivers a proper standard of nursing should provide:

- selection of recruits who evidence the appropriate values, attitudes and behaviours
- training and experience in delivery of compassionate care
- leadership that constantly reinforces values and standards of compassionate care
- involvement in, and responsibility for, the planning and delivery of compassionate care
- constant support and incentivisation that values nurses and the work they do.

These are further expanded upon in recommendations 186 to 189 and include a suggestion that there should be a “national entry-level requirement that nursing students spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse” (recommendation 187).

What is the RCN’s position on the recommendations?
The RCN supports the need for a consistent UK-wide framework for pre-registration nursing education but asserts that it would be premature to make further changes to pre-registration nursing education until the changes made in 2010 have been evaluated.

The evidence from the Willis Commission (see “What is the relevant evidence?”, below) and recent literature suggests that the primary focus for work on pre-registration nursing education should be the experience of students on their practice placements. The commission stated explicitly: “There were no shortcomings found in nursing education that could be directly responsible for poor standards of care or a decline in care standards.”

In that sense we need to see students as a “positive catalyst for change: part of the solution not the problem” (Council of Deans, 2013). The assumption that nursing students’ values are not tested in any way during their recruitment, education or qualification is not borne out by the day-to-day experience of thousands of students across the UK and does not reflect the requirements of the Nursing and Midwifery Council (NMC) standards for education. The NMC requires higher education institutions to put in place two progression points separating the education programme into three equal parts. Progress in acquiring the competences is mapped through the use of minimum progression criteria, based on safety and values. The first progression point is normally at the end of year one. To pass the second progression point, normally at the end of year two, students need to demonstrate that they can be more independent and take more responsibility for their own learning and practice. The job at hand is therefore to combine existing testing with a more positive practice placement for students who are aligned to mentors valued by their employers.

The RCN believes that effective practice placements tend to have appropriate levels of skilled staff and visible, supported and valued professional leaders with time to give to the important task of supervision. These placements often exist in organisations that have stronger relationships with higher education institutions and other providers of care services in and outside the NHS. A more effective partnership between education and practice should be the focus for further work.
The RCN does not believe that there is wide enough recognition of the fact that pre-registration programmes already ensure that nursing students undertake 2,300 hours of practice (50 per cent of their total education time) in clinical care settings. This is a European Union legal requirement monitored in the UK by the NMC.

Francis’ recommendation (187) that “there should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse” seems not to acknowledge the extent of practical experience already on offer throughout UK pre-registration programmes of education.

The RCN is supportive of universities that look for candidates who can demonstrate previous experience in delivering care. Furthermore, UK pre-registration programmes already involve direct care of patients, including older people, and substantial hands-on physical care. There are also procedures in place to ensure that satisfactory completion of this direct-care experience is a determining factor in being allowed to continue on the course. However, there is anecdotal evidence that suggests a mixed picture regarding how consistently these procedures are applied.

Therefore, while the RCN supports the need to improve the consistency and quality of some practice placement experiences, the RCN does not believe it is necessary to add to practice placement hours. The RCN Education Forum contributed towards the development of the NMC’s 2010 standards for education and believes these to be robust when adhered to correctly. (The UK requirements for nursing students to work a particular number of hours in practice has not changed since 1971. It is notable, however, that there is no evidence that more hours over three years is any more effective in preparing students than international models offering clinical supported learning and simulation but fewer hours in practice. For example, the requirement in the USA is only 1,000 hours.) The main focus of future work should be to tackle poor quality learning environments or poorly supervised practice that can socialise prospective students into poor practice and inhibit their development as nurses (Mackintosh, 2006; Curtis et al., 2012).

Where there are concerns about a student’s aptitude for compassionate nursing this is best dealt with in a structured programme of education and development that should contain ample opportunity to examine a student’s grasp of both theory and practice.

It is important to point out that post-registration education and continuing professional development (CPD) are fundamental to the development of all health and social care practitioners, and provide the mechanism through which high-quality patient and client care is identified, maintained and developed.

Previously, in a joint statement on CPD for health and social care practitioners in 2007, the RCN, along with a number of other professional bodies across the UK, recommended that:

- at least six days (45 hours) per year protected CPD time should be granted to support health and social care practitioners’ as a minimum, and in addition to existing statutory and mandatory training and formal study leave arrangements. This is a realistic amount of time, and is in keeping with other existing regulatory and professional body requirements
- employers should ensure appropriate staffing levels are in place to maintain standards of care and service delivery when protected time is taken. This provision should be made available to both qualified health and social care practitioners and support workers
- employers should seek to go beyond the minimum protected time allocation to ensure individual learning needs are met and staff are enabled to develop the necessary skills required by patients and their carers in an increasingly complex and challenging care environment.

What is the relevant evidence?

There are two themes that emerge from the Francis recommendations on education and training for nursing. Firstly, it is suggested that there is a need to review curriculum content to ensure it provides for appropriate clinical and practical preparation for practice.

Secondly, there is a suggestion that additional tests need to be put in place before someone gains access to a career as a registered nurse.

The first matter (that nurse training needs reviewing to ensure “sufficient practical elements are incorporated to ensure that a consistent standard is achieved”) has been addressed through a number of reviews since the inception of Project 2000. The NMC and its predecessor, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, both instigated important reviews of curriculum content with a particular emphasis on the practical skills elements and the process of assessment (NMC, 2005).
We have previously stated that it would not seem appropriate to review national pre-registration curriculum standards so soon after the last review, which was published by the NMC in 2010. The first students to be educated under those standards will enter practice in September 2013. A proper evaluation should be undertaken to ensure that, among other things, the programmes are producing staff who deliver “high quality, safe, essential care” and do so with “integrity and professionalism” (NMC, 2010).

Some of those standards address the role of the mentor who is required, among other duties, to have completed specific preparation in assessing students, be responsible for ongoing supervision and assessment in practice settings and, in some cases, sign off students who are judged to have reached the required competences in the field of practice (see Standards to support learning and assessment in practice (NMC, 2008)).

The NMC requires higher education institutions to make “direct links between what is assessed in practice and academic settings, with the processes overseen by external examiners to ensure that theory and practice remain integrated”. The assessment of theory and practice learning should be given equal weighting.

Rather than review fairly new national standards, there are many who suggest that attention should be turned to the quality of the learning environment in which pre-registration students are supported in applying theory to practice. This is particularly true in the preparation of and support for the role of the mentor.

Preparing mentors for their role and responsibility is vital, as is adequate support from both education providers and employers. High quality learning environments depend on mentors who have developed their own knowledge, skills and competence beyond first registration and have been prepared for their role by completing an NMC-approved teacher-preparation programme (NMC, 2008). In addition to meeting those principles, successful mentors display and model leadership attributes, as well as playing a supporting role for students in alleviating anxieties. They also support students with socialisation into both the higher education and clinical contexts.

Because of the demands of the mentor role, evidence suggests that employers must take steps to ensure mentors are valued, recognised, protected from excessive clinical workload, and supported through peer networks and regular supervision. The consequences of providing poor mentorship are clear. A study by Duffy (2003), funded by a scholarship from the NMC, reviewed why mentors and practice placements seemed to “fail to fail” students who were falling short of the standards required. The study revealed that students appeared to pass clinical assessments even when there were doubts about clinical performance. Further it identified that weak students often had a history of problems within clinical practice but had usually been given the benefit of the doubt and so progressed through the system (Duffy, 2003). This was due in no small part to mentors lacking the required skills and not receiving the proper support of the respective educational or employer organisations.

The Willis Commission on the future of nursing education was launched in February 2012 and reported in October 2012. Its remit was to gather evidence on the best methods of delivering pre-registration nursing education in the UK and review how efficient the current education system is, looking in particular at the balance between workplace and classroom learning.

The commission considered the following question: “What essential features of pre-registration nursing education in the UK, and what types of support for newly registered practitioners, are needed to create and maintain a workforce of competent, compassionate nurses fit to deliver future health and social care services?”

The commission’s independence was assured by the appointment of Lord Willis as chair and a panel of seven experts from across the UK, comprising service-user representatives, nurse educationists, managers and practitioners. The commission was supported by special advisers, a secretariat comprising RCN staff on secondment and an independent consultant.

The commission made a number of recommendations that address Francis inquiry recommendations directly and the issues outlined above. It recommended:

- supporting the need for a more diverse clinical experience during education
- national regulation of health care support workers
- further research to expand the pre-registration evidence base
- more support for the nursing academic workforce and urgent steps to be taken to guarantee its future quality
- investment in a national clinical-academic career structure
- provision of properly supported and recognised...
mentorship and support for students in clinical placements.

**What has the RCN done already in this area?**

**RCN Education Forum**
The RCN Education Forum steering committee comprises nurse educators appointed to support and represent the collective views of nurses on educational policy and practice. The forum’s active membership includes nurses working to provide education in acute and primary care practice settings and within education institutions delivering further, higher and specialist nursing education.

As part of its work the forum runs conferences to share best practice, such as *Celebrating Excellence*, an event specifically designed to offer support to mentors of nurse learners in practice. The forum is particularly concerned about the public perception that nursing education and nursing students are at fault for an apparent lack of compassion in nursing. It recently submitted a resolution to RCN Congress calling for nurse mentors to have proper time and recognition to fully support students on practice placements. The resolution was passed, with more than 98 per cent of voting members in favour. One member summarised the RCN’s views by saying: “The right support, at the right time, in the right place will develop the workforce of the future.”

**RCN Principles at work**
We support the continued introduction of values-based recruitment of students into pre-registration programmes of education for nursing and indeed for all other health care disciplines where there are properly validated tools in existence, and where such approaches are combined with other procedures to ensure students are viewed in the round. Being a nursing student requires a range of skills and aptitudes in addition to the ability to care and show empathy. However, not all of those skills can or should be tested at recruitment. Some skills develop over time and the current assessment and supervision process is designed to support students as they develop during their practice.

Since their launch, the RCN principles of nursing practice have been used by a growing number of organisations for a range of initiatives aimed at improving patient care. For example, they are being used to present a positive articulation of good nursing practice, as a tool to support reflective practice among students and registered nurses, as an assessment framework in recruitment processes (for employment and pre-registration education), as a framework for preceptorship and to provide a focus for practice development in the workplace.

**Supporting health care support workers in practice**
A more detailed section on issues surrounding health care support workers (HCSWs) can be found below. However, it is worth stating here, the RCN view that HCSWs and assistant practitioners (APs) are hugely valued members of the RCN and the nursing team. We support them through our national HCSW and AP networks and provide online support through our First Steps resources, which cover issues such as accountability and delegation. We also provide quality-assured resources on regulation, record keeping and roles within the nursing team.

We support the introduction of national standards for HCSW training and supervision but believe that this can only have maximum effectiveness when combined with statutory, national regulation. We are pleased to note that this recommendation from the inquiry is also supported by many public and patient groups.

**What does the RCN believe needs to happen next?**
The RCN has already committed to reviewing its existing guidance for mentors and students (RCN, 2007).

The RCN will also work with strategic partners to support the consistent development of a learning environment fit to support students in pre-registration education programmes. This joint work should look at the following issues:

- skilled mentors using established learning approaches directed to individual student learning styles. This level of ability requires sustained organisational investment in mentors – it is not a role that can be squeezed into an already demanding clinical or managerial workload nor can it be picked up along the way. Accredited education and development must be made available for mentors
- the mentor’s role goes beyond teaching knowledge and skills; it involves displaying and role-modelling leadership attributes, as well as playing a supporting role such as alleviating anxieties, and supporting students with socialisation into both the higher education and clinical contexts (Ousey, 2009). As such mentors should be supported to develop peer-to-peer networks and receive structured and predictable support from higher education institutions in discharging their responsibilities, particularly when new to the role
- consideration should be given to introducing a system
whereby nurses choose to be a mentor. Potential mentors could then be selected on their values, motivations and attributes (Black, 2009)

- time required to fulfil the sign-off mentor role should be taken into consideration when allocating workloads. Managers may wish to consider the importance placed on this gate-keeping role within their organisations by raising the profile of sign-off mentors

- the mentor role should be developed into one that is recognised and respected within the profession and health care organisations (Mead et al., 2011)

- there should be dedicated and uninterrupted time for group and individual seminars and tutorials (Jarvis and Gibson, 1997).

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3.7 Leadership

**Summary**

Robert Francis rightly identified that a lack of visible leadership, with connections between the board and the ward, contributed to the failings at Mid Staffordshire.

Strong leadership, including from nurses, is required at both national and local level, and the RCN has a critical role to play in supporting this vision.

The RCN strongly supports Francis’ recommendation regarding the role of the chief nursing officer and believes that it is a vital position to both challenge and champion the nursing profession.

Furthermore, and with a particular focus on England’s newly formed clinical commissioning groups (CCGs), the RCN supports nurse leadership at every level of the NHS. The RCN fought hard to secure a nurse position on the boards of CCGs as we understand the unique contribution that nursing can make to commissioning decisions.

Leadership is not something that is solely seen in boardrooms or the corridors of power; it is often delivered on hospital wards and in our communities. In particular, ward sisters have a vital role to play in acting as leaders, mentors and educators.

The RCN believes that ward sisters are the leaders whom patients wish to see most, making decisions about a patient’s care and acting as the visible leader of care delivery.

As such ward sisters need to be freed from their clinical duties so that they have the time to lead, mentor and educate their fellow nurses. We believe this move would contribute to delivering on Robert Francis’ vision for strong leadership in the NHS that delivers a tangible benefit to patients.
What did Robert Francis recommend?
In his report, Robert Francis recommended:

- 203: A forum for all directors of nursing from both NHS and independent sector organisations should be formed to provide a means of co-ordinating the leadership of the nursing profession.
- 204: All health care providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.
- 205: Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.
- 206: The effectiveness of the newly positioned office of Chief Nursing Officer should be kept under review to ensure the maintenance of a recognised leading representative of the nursing profession as a whole, able and empowered to give independent professional advice to the Government on nursing issues of equivalent authority to that provided by the Chief Medical Officer.

Leadership features prominently in the Francis report. A number of recommendations focus on the standing of the profession and the need to strengthen nursing leadership and the nursing voice at the organisational level, particularly by improving the competence and accountability of leaders and increasing nursing representation in decision making.

What is the RCN’s position on the recommendations?
The RCN fully supported the establishment of the role of chief nursing officer (CNO) (recommendation 206) and is clear about the distinct and complementary nature of that function and the RCN’s own role as the professional body for nursing. This is an ongoing relationship and one that is constantly being developed.

The RCN has a long history of providing evidence and advice to senior nursing leaders in the civil service and supporting the implementation of government-led initiatives to enhance care quality, safety and nursing.
What is the relevant evidence?
All leaders, including nurses, are most effective when working in an organisational culture that enables leadership and focuses more on the efficacy of multidisciplinary teams, the organisation and a shared purpose than on individual leaders (King’s Fund, 2012).

Perceptions of fairness are particularly important, with strong evidence linking this to group identification, compliance with rules and procedures, effective decision making and positive communication between staff and managers (Blade and Tyler, 2009; Greenberg, 2011).

Nursing staff are important clinical leaders who make a difference to patient safety, mobilising resources, and designing and implementing solutions (Charles et al., 2011; Richardson and Storr, 2010).

Key to ward leaders’ effectiveness is their role as educators and enablers of change who can enhance individuals’ knowledge and skills through clinical experience, by actively involving staff and using multi-faceted approaches to learning that reflect local context and resourcing (Francke et al., 2008; Grimshaw et al., 2004; Lomas et al., 1991; Menon et al., 2009).

In particular, ward leaders can ensure that delivery of ongoing education and training is integrated into routine practice, an approach found to be significantly more effective in developing appropriate attitudes and behaviours than classroom-based approaches (Coomarasamy and Khan, 2004).

Models of leadership that are focused on values rather than specific ways of working would be an important topic for a renewed focus on leadership development and training.

There is strong evidence that ward leaders and their staff benefit from undertaking collaborative learning and development; this improves pupil (nurse) learning and behaviour as well as teacher (ward leader) practice, attitudes and behaviours (Cordingley et al., 2005).

Although patient safety is a priority, it is often still not explicit within formal health care training curricula (Attree, 2007; Pearson et al., 2009) and where it is taught, coverage may be patchy and the approach to teaching inconsistent, with relevant organisational issues absent (Pearson et al., 2009). Incident reporting, for example, is not incorporated to any great extent in undergraduate curricula for nurse, medical, pharmacy or physiotherapy education (Pearson et al., 2010). The RCN would like to see a commitment to developing up-to-date curricula for patient safety that can be adopted by employers and education providers.

What has the RCN done already in this area?
The RCN Executive Nurse Network provides executive nurses and aspiring directors across all sectors and across the UK with a confidential, supportive environment for sharing and developing ideas or solutions (recommendation 203). The network has the potential to provide a forum for co-ordinating learning and development and other activities in support of senior nurses.

The RCN principles of nursing practice reflect the importance the RCN places on leadership at all levels as essential to the quality of nursing care patients can expect. Principle H states: “Nurses and nursing staff lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.”

The RCN is a member of the Academy of Nursing, Midwifery and Health Visiting Research, a collaborative enterprise with the Community Practitioners’ and Health Visitors’ Association, the Royal College of Midwives, the Council of Deans for Health, the nurse directors’ group of the Association of UK University Hospitals, the Association for Leaders in Nursing, the Queen’s Nursing Institute, the UK Clinical Research Facility Network, and Nurses in Primary Care Research. The academy provides a collective voice on research issues and, in particular, action to promote clinical academic careers. Additionally, the RCN provides support to researchers and innovators in nursing through its networking and learning and development activities.

The RCN recognises the importance of leadership training (recommendations 196, 197 and 214) and has prioritised learning and development for leaders since the mid-1990s (Cunningham and Kitson, 2000a, 2000b), offering a successful clinical leadership programme (Large et al., 2005). The College continues to offer a range of bespoke and online resources to support senior nurses working to develop and enhance their leadership skills and knowledge.

The RCN also offers complementary safety and care improvement resources, delivered through face-to-face and online media, including a public-facing online resource on patient safety. The resources use a human factors framework to understand the factors that impact on safety.
and to identify action that can be taken to mitigate their effects. Leadership is integral to the framework.

The structure and learning approach of our programmes is consistent with evidence that students learn most effectively when a variety of approaches is used that reflect the range of competences they are expected to develop (Kozd and Campbell, 2010; Leskiw and Singh, 2007). Our programmes are also closely aligned to the current NHS Leadership Framework and we provided “real-life” leadership scenarios from students, health care support workers, newly qualified and senior nurses to inform the development of the NHS Institute Clinical Leadership Competency project. We are now contributing to the review of the framework by the NHS Leadership Academy (recommendation 216). We will consider what would be the most effective action for the RCN to take to enhance nursing leadership at the conclusion of that review. In the meantime, we are continuing to offer resources for leaders and to support them in practice through our existing work.

The RCN has consistently identified the nursing ward leader role as pivotal to the achievement of person-centred, safe, effective care. To be effective, ward leaders should be visible, accessible role models who set and demonstrate standards of care (recommendation 195). We have, therefore, consistently made the case for the supervisory status of ward leaders (RCN, 2009, 2010b) and have supported NHS organisations to implement this in practice, offering guidance, learning and development opportunities (RCN, 2010b).

What does the RCN believe needs to happen next?
Ward sisters are a fundamental part of the NHS workforce, and are essential in overseeing the delivery of safe, high-quality care for patients. However, the RCN believes that all too often ward sisters are not empowered to lead the care they deliver. Perhaps most worryingly, we know that the majority of ward sisters simply do not have enough staff on the ground to deliver the care they would wish.

In a recent RCN survey, more than two-thirds (69 per cent) of ward sisters reported a difference between the numbers of nursing staff deemed necessary to staff wards and community nursing teams safely and the actual numbers of nurses in place.

Of these, the vast majority (86 per cent) said that they were understaffed; a quarter (25 per cent) said understaffing was due to vacancy freezes being imposed and 27 per cent reported that posts were being cut permanently.

There is evidence that team training approaches that combine leadership strategies with other tools can have a positive impact on health care team processes and patient outcomes (AHRQ, 2013). The RCN supports the use of approaches to learning that align the leadership aspect of team training with other effective learning and development strategies, such as training in the use of human factors and simulation-based training (AHRQ, 2013), as an effective influence on delivering safe, effective services.

The RCN firmly believes that strong nursing leadership will be critical in a number of newly emerging NHS organisations such as clinical commissioning groups. Boards will need to ensure that they seek substantive, skilled nursing leaders who can bring experience of patient safety, quality improvement, service delivery and workforce planning to bear on commissioning decisions.

As well as the impact of leaders in practice, the RCN also recognises the important leadership role played by nurses in academic careers who teach and contribute to the evidence base for leadership and practice.

The 2012 Willis Commission examined the provision of pre-registration nursing in the UK (Willis Commission, 2012) and highlighted major challenges for students in developing clinical expertise rooted in evidence and the continual development of a professional knowledge base that addresses practice priorities. The RCN shares the commission’s concerns and supports its recommendation for a national clinical-academic career structure that could support engagement with and leadership of research, together with greater investment in collaborative research between universities and health care providers to develop the evidence base of nurse education.

References


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3.8 Older people’s nursing

**Summary**

Of the many challenges currently facing the health service, few are as significant as the need to improve the care given to older people.

There is no single fix for the standard of care delivered to this patient group, and the RCN believes that a number of the chapters in this document are relevant to the care of older people. We need safe staffing levels, properly trained and regulated support staff, and improved methods for raising concerns about poor care. Older people should not be considered a burden; they are the single biggest users of the NHS and yet often receive some of the poorest care. This has to change.

In care homes across the UK, the vast majority of care delivered to older people is provided not by registered nurses, but by health care support workers. As is advocated in other chapters, these staff need consistent training and full regulation. The situation at the moment is nothing short of scandalous. Health care support workers are integral to both the NHS and independent sectors, but many receive little or no training and there is no single register documenting who they are.

In terms of Robert Francis’ recommendations, the RCN believes that all nurses need to be provided with the right skills to deliver excellent care to older people. Therefore, rather than pre-registration recognition, we believe we need nationally recognised career pathways for those wishing to further develop their expertise in this area of practice.

The RCN has undertaken a significant amount of work around the care of older people, including seminal reports on staffing levels and identifying the crucial elements of good care for this growing demographic.
What did Robert Francis recommend?
In his report, Robert Francis recommended:

- **200:** Consideration should be given to the creation of a status of registered older person's nurse.

The Francis inquiry found that much of the poor care and neglect described concerned older patients. It noted that “older people require a skilled and multi-disciplinary team approach”; and that “active management with the assistance of specialist advice will often be needed”.

What is the RCN’s position on the recommendations?
The RCN believes that nursing has a significant role in supporting high-quality care for older people and that all nurses and health care support workers (HCSWs) need to be adequately prepared for this role, supported by the right resources, sufficient staffing levels and the right skill mix.

We believe that all nursing staff should be competent to give compassionate, knowledgeable and skilled care to older people, and have access to specialist services.

The RCN supports nationally recognised education and career pathways for those wishing to further develop specialist skills in this area of practice. We believe this route is a better option than pre-registration status as the delivery of excellent care to older people should be something that every nurse understands. We are pleased to note that Health Education England (HEE) has committed to addressing this in its recently published mandate (DH, 2013) and that HEE will work with higher education institutions and others to “review the content of pre-registration nurse education to ensure all new nurses have the skills to work with older people being treated in the health care system”.

What is the relevant evidence?
With increasing numbers of older people who are frail, often with complex needs and co-morbid conditions, caring for older people has become a major part of health care provision.

Hospital care, in particular, has become an area of significant concern over the last few years (Banerjee and Conroy, 2012; Royal College of Physicians 2012). The number of admissions is rising faster among older people than for any other age group. People over 65 occupy approximately 70 per cent of hospital beds (Commission for Healthcare Audit and Inspection, 2006) and 68 per cent of emergency bed days (Imison et al., 2012). Those who are admitted often have a high acuity, and many have dementia and/or delirium in addition to their presenting condition (RCN, 2012; Royal College of Physicians, 2012). Moreover, the number of older people living in the community and in care homes with complex health needs and requiring skilled nursing care is on the rise.

Caring for older people is highly complex and requires skilled, trained staff who have been given adequate education, training and support. The knowledge, skills and aptitudes required to achieve high-quality care for older people needs to be valued, recognised and afforded a higher status. However, despite policies that have recognised the need for specialist knowledge in the care of older adults and improvements in care (DH, 2001; Scottish Executive, 2007; Welsh Assembly Government, 2008), working with older people is still considered low status (Cornwell, 2012).

The role of HCSWs in monitoring and providing direct care to older people has also increased but the availability of appropriate education and supervision is limited.

Banerjee and Conroy (2012) argue that “all staff involved in assessment and examination must have competence in older people’s care needs and have an in-depth understanding of long-term condition management”.

What has the RCN done already in this area?
The RCN has repeatedly raised concerns about poor staffing levels, with many nurses saying they are too busy to provide the standard of care they would like. Evidence collected by the RCN (March 2012) indicated that currently one nurse cares for about nine patients on older people’s wards. The RCN believes that this is simply not enough to provide basic, safe care which we believe requires one nurse to seven patients. Ideally, there should be at least one registered nurse for between five and seven patients.

The RCN has, for many years, recognised the complexities and skills required in caring for older people and the essential role of nursing in providing high-quality care as part of the multidisciplinary team. A number of work-streams and publications highlight these issues (RCN, 2004, 2007, 2008a, 2008b, 2012a, 2013). These publications offer guidance on the adequate preparation of nursing students, report on skills required to assess and support complex needs and offer tools to support nursing in providing high-quality care for older people.
The RCN’s *Improving hospital care for older people* initiative brought together a range of stakeholders including leading members of royal colleges, charities, think-tanks and practitioners who have an interest in the care of older people in hospital. They met in October 2012 to discuss key issues and concerns, to identify good practice and latest thinking, and to form consensus on some key areas for action.

Outputs from this event were widely disseminated with the aim of sharing good practice, triggering action to improve hospital care for older people and informing future planning, commissioning and delivery of hospital care for older people.

Overall, seven main themes were identified as necessary to support improvement in hospital care for older people. These were:

- person-centred care
- dignity and compassion
- training and competence
- staffing levels
- safeguarding
- resources
- culture and structure.

All the delegates signed a pledge calling on commissioners and hospital providers to give assurance that the training and competence of staff, the culture and structure within hospitals, and the adoption of person-centred care service models should be priority areas for development in the care of older people. Delegates described further actions under each of the three headings and, along with the RCN, committed to develop the evidence and tools required to support organisations in delivering upon this pledge.

More recently, the RCN has also produced guidance and resources to support improvements and raise standards in the care of older people and people with dementia in hospital. These have been well received and are being used widely to inform practice across the UK (see RCN, 2012a, 2012b, 2012c).

**What does the RCN believe needs to happen next?**

Greater emphasis on nursing older people is required within all pre-registration programmes, including adult, mental health and learning disabilities, to support the development of empirical and tacit knowledge, as well as skills, within clinical practice.

Educational requirements and learning outcomes for working with older people need to be strengthened and incorporated early within pre-registration programmes as specific modules. These should also be threaded throughout the curriculum so that all qualifying nurses have a critical understanding of the ageing process, its impact on other conditions and how to provide high-quality care for older people.

The RCN is particularly keen to contribute towards the development of a post-registration, nationally recognised and accredited qualification in the care of older people and that “specialist practitioner: older people” (SPOP) and for that to be recordable with the Nursing and Midwifery Council (NMC), in line with other specialist practitioner qualifications.

The need for specialist education and roles in the care of older people is well recognised (Heath, 2006; Kydd et al., 2013; Reed et al., 2007). Studies on the impact of gerontological nurse practitioners, including community-based roles, suggest that such roles can help reduce length of stay, lead to reductions in adverse events and lead to improved outcomes for older people (Newhouse et al., 2011; Parke et al., 2012; Ryden, 2000).

To support the above recommendations the RCN will:

- establish knowledge, skills and competencies for nurses working with older people at a range of levels and within different settings
- support the development of national career frameworks with accredited access points for specialist and advanced practice in older people’s care
- engage with HEE, higher education institutions and the NMC to develop pre and post-registration education for older people’s nursing
- call for a career pathway for nurses so that teams have access to specialist knowledge and expertise such as older people’s specialist nurses and consultant nurses.

**References**


3. The RCN’s response to the key issues in the Francis Report


3.9 Information (records and reporting)

Summary

Robert Francis’ recommendations on the issues of information, patient records and reporting resonate with other work the RCN has been involved in. Robert Francis proposed common information practices, something which the RCN believes is important in delivering the consistent approach that the NHS needs. We therefore broadly welcome the recommendations set out in this area.

It is important to note that the seminal report on this issue was published in April 2013 by Dame Fiona Caldicott. The report, for which the RCN was a contributing organisation, offers clear and sensible guidance about how the NHS can improve the way in which providers share information with each other and with their patients.

An obvious way of improving the means by which information is shared is through the use of information technology (IT). It is fair to say that the NHS does not have a good track record in terms of the introduction of IT, with money often being spent on projects that fail to materialise. To secure the future of effective IT, health professionals must be better involved if projects are to be a success.

The RCN has undertaken a significant amount of work in this area, not least working with the British Computer Society to showcase examples of innovation and strategic direction, which raised the profile of nursing with system suppliers and information managers.
What did Robert Francis recommend?
In his report, Robert Francis recommended:

- **243**: The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.

- There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems:
  - Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way.
  - Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry.
  - Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered.
  - Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.
  - Systems must be designed by health care professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements.
  - Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.

What is the RCN’s position on the recommendations?
The RCN broadly welcomes the recommendations made by Francis with regard to recording care and sharing information. The authoritative work on much of this topic can be found in the second Caldicott review (DH, 2013) to which the RCN and its members made a significant contribution.

What is the relevant evidence?
The 2012 RCN eHealth survey found that most participants use information and communication technology (ICT) daily at work, but only 31 per cent have sole use of a computer. One third said that their level of access to ICT and the ICT tools they use are not adequate for their role. Seventy per cent of respondents use ICT for clinical record keeping and 87 per cent use it for communication; but less than 50 per cent use systems for clinical audit or outcome measurement.

Seventy-eight per cent of respondents have little or no influence over eHealth developments; 45 per cent think that clinical information systems increase the burden of administration and 53 per cent believe that they duplicate paper records.

What has the RCN done already in this area?
The RCN position on eHealth supports use of appropriate health IT systems and the overall aims of national health IT initiatives. We agree with Francis’ recommendation (244) that systems must be designed by health care professionals in partnership with patient groups and that information should be recorded once only wherever possible.

A number of RCN guidance documents – for example, **Putting information at the heart of nursing care** (RCN, 2006) – and other resources relate to record-keeping, communication, use of technology and re-use of data to monitor and improve outcomes. In collaboration with national nursing groups across the UK, we are working to identify common quality standards and measures for record keeping and for the nursing content of patient records. We work in partnership with professional and patient representative organisations, system suppliers and frontline nurses to share good practice, identify barriers and consider solutions for improvements.

For example, at a recent British Computer Society conference the RCN showcased examples of innovation and strategic direction that raised the profile of nursing among system suppliers and information managers, and encouraged nursing participation in influencing the direction of eHealth.
3. The RCN’s response to the key issues in the Francis Report

As a founding member of the Professional Record Standards Body the RCN is committed to ensuring that systems support best practice for record keeping and accurate data for quality monitoring. The RCN also has representation on strategic stakeholder groups, such as national nursing groups and NHS Mail, and supports enterprises such as the Chief Clinical Information Officer Network.

What does the RCN believe needs to happen next?

We welcome the Government’s efforts to reduce data-collection burdens for frontline staff. However, until useful and useable ICT is available to support the recording of nursing care, automatic data gathering to monitor quality and performance will not be possible. We agree with Robert Francis that resources need to be made available to collect and transfer data where systems do not provide it so that frontline staff are able to spend their time caring for patients.

The RCN would like to work with national leads and other professional organisations to:

- promote informatics skills for nursing staff, to equip them to plan, collect and use information recorded as part of the care process
- promote clinically led development and implementation of record-content standards to support data re-use, system interoperability and clinical communication
- consult and engage with nursing staff to ensure the most appropriate technology is selected
- promote the role of senior nurses on clinical commissioning groups to influence nursing input to service transformations facilitated by ICT
- re-establish the professional principles and values of record keeping within the digital context so that it is not seen purely as data collection.

References


3.10 Nursing standards

Summary

As the professional voice for nursing, the RCN has undertaken a huge amount of work in developing, promoting and embedding nursing standards across the UK.

Our principles of nursing practice, highlighted throughout this document, have been a flagship piece of work and have sought to allow everyone to understand what good nursing looks like.

In terms of Robert Francis’ recommendations, we support all moves to further underline what quality care is, and how the NHS should deliver it. The only caveat to that is that those expected to deliver patient care are given the time, resources and freedom to do so.

As can be seen from this chapter, the RCN has achieved much in recent years and has high expectations of what must be achieved in the years to come.
What did Robert Francis recommend?
In his report, Robert Francis recommended:

- **9:** The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including the Code of Conduct for NHS Managers.
- **10:** The NHS Constitution should incorporate an expectation that staff will follow guidance and comply with standards relevant to their work, such as those produced by the National Institute for Health and Clinical Excellence and, where relevant, the Care Quality Commission, subject to any more specific requirements of their employers.
- **11:** Health care professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.
- **12:** Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.

What is the RCN's position on the recommendations?
The RCN agrees that professionals are required to adhere to professional standards and that these should define the values, skills and behaviour expected of members of the profession in question.

Additionally, patients and colleagues should expect that members of a profession, in this case nurses, will make decisions based on evidence of effectiveness, as determined by robust scientific standards. We also agree that where feasible, procedures, processes and systems should be standardised to promote evidence-based practice and reduce error.

More attention to the standardisation of technology and drugs would also help to promote patient safety.

However, the RCN is concerned that focusing solely on an individual professional's adherence to standards, codes and guidance will not alone change the care experienced by patients. Evidence shows that there are multiple influences on nurses' ability to deliver effective, safe, patient-centred care (Rejon and Watts, 2013; Scrivener and Watts, 2013). We believe, therefore, that action should be taken to mitigate the negative influences on professionals' attitudes and behaviour; to support individuals in developing, maintaining and overtly living their professional values; and to promote an environment that enables professionals to adhere to guidance and standards, and to deliver effective care. We are therefore pleased that achievement of the fundamental standards will be the responsibility of organisations, not individuals, and hope that this will be clearly reflected in the phrasing of these standards.

What has the RCN done already in this area?
The RCN has set out a clear set of nursing values in the eight principles of nursing practice. The principles, developed by the RCN in partnership with the Department of Health (England), the Nursing and Midwifery Council, and patient and service user organisations, are the RCN's statement of nursing's professional values. They provide a robust, clear description of what everyone can expect from nursing. The RCN uses the principles to underpin our approach to nursing quality measurement, practice improvement and professional education.

The components of the principles are reflected in the NHS Constitution, the Chief Nursing Officer for England’s “6 Cs” and in the values and standards documents of other organisations (Watterson, 2013). As such, the principles provide a common language for stating, using and learning the professional values for nursing and are applicable to registered nurses and to health care support workers (Watterson and Dickens, 2012; Watterson et al., 2012). The RCN supports organisations and nursing teams to use the principles in practice at all levels within their services – through direct support to leaders using the principles for strategic planning; for measurement and care improvement; and by providing tools and techniques based on the principles to promote reflective learning by students (Watterson, 2013).

The RCN takes an active role in the production of standards and guidance designed to promote evidence-based practice. Expert members, staff and partner organisations, including patient representative organisations, develop, disseminate and maintain evidence-based, consensus
standards and guidance to support the delivery of quality nursing care and services. These essential resources cover nursing practice, services, education and competence, workplace issues, staffing and other topics.

Easily accessible through the RCN website and specialist forum pages, there are multiple examples of these essential resources and the implementation support tools that accompany them; for example, quality checklists, online learning opportunities and audit tools. Examples of standards publications from March/April 2013 include:

- **Better medicines management** (RCN, 2013a)
- **Rights, risks and responsibilities in service redesign for vulnerable groups** (RCN, 2013b)
- **The management of diarrhoea in adults** (RCN, 2013c)
- **Training and education framework for fertility nursing** (RCN, 2013d).

The RCN works with expert members, partner organisations including patient and other professional organisations to contribute to and develop National Institute for Health and Care Excellence (NICE) quality standards and guidance. This is an active area of work, with a dedicated unit in the RCN responsible for engaging with NICE through all the various NICE work programmes – for example, from identifying expert nurses to participate in the development of the guidance, to contributing to the development of the standards, and finally supporting nurses with the implementation of the published standards and guidance.

Through the RCN NICE consultation gateway members are kept abreast of current NICE activities and are actively encouraged to participate in the development of NICE work. This provides an opportunity for members to share best practice for high quality care and supports their continuing professional development. Examples of NICE standards and guidance published in March and April 2013 that the RCN was involved in, and which are available on the NICE website, include:

- **Supporting people to live well with dementia (QS30)** (NICE, 2013a)
- **Rheumatoid arthritis – abatacept (2nd line) (rapid review of TA234) (TA280)** (NICE, 2013b)
- **Hyperphosphataemia in chronic kidney disease (CG157)** (NICE, 2013c).

National standards and evidence-based resources developed by other organisations are often of relevance to nursing. The RCN is usually involved in the development and dissemination of such standards and/or formally endorses them to promote widespread adoption by the UK nursing professions. Examples from March/April 2013 include vitamin D and bone health, and cardiopulmonary resuscitation – standards for clinical practice and training.

The RCN believes that standards and guidance should be actively disseminated and practitioners helped to use them in practice. It therefore invests in a specialist nursing knowledge service that holds and continuously develops the most extensive collection of professional nursing resources in Europe.

From summer 2013, the public will be able to use these knowledge resources, find out about nursing standards and participate in a new programme of events and seminars to be held in our publicly accessible library.

The RCN also alerts members to new standards and guidance, and develops targeted resources to bring together standards, evidence of effective practice and factors that enhance patients’ experience of care. We also provide face-to-face and online learning and development opportunities.

Our patient safety pages are an example of a target resource and can be found at [www.rcn.org.uk/development/practice/patient_safety](http://www.rcn.org.uk/development/practice/patient_safety)

Complementing RCN standards and professional resources, the RCN provides telephone advice on clinical issues, including direct communication with specialist nursing advisers. Over the coming year, we are strengthening support for frontline staff on professional issues with the appointment of learning development facilitators in each RCN regional office.

The RCN contributes to the development of standards used in inspection and to regulate care providers. We are members of the Care Quality Commission expert reference group developing its proposals on fundamental standards of care following publication of the Francis report.

**What does the RCN believe needs to happen next?**

The RCN is working to improve the way it communicates and disseminates the principles of nursing practice and the essential standards work carried out by expert members, researchers, staff and partner organisations.

As the recommendations made by Robert Francis are implemented, we would like to see this work and the supporting implementation resources evaluated and used
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rather than replicated. As the UK’s professional body for nursing we wish to:

- work with NHS England, royal colleges, professional bodies and regulators to establish coherent and easily accessible structures for the development and implementation of values, and fundamental, enhanced and developmental standards, as recommended in the Francis report
- be fully involved in the formulation of multidisciplinary standards and in the means of measuring compliance, working closely with the CQC, NICE, commissioners, other professional organisations, patients and the public
- continue to work with partners across the clinical team to identify and fill gaps for evidence-based standards and guidance relevant to nursing, taking account of priorities identified by patients and the public, as well as RCN members.

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Further reading

3.11 Safe staffing levels

Summary

There are often a number of contributory factors that lead to poor patient care, but few are as pronounced or tangible as the impact of unsafe staffing levels. This was made clear at Mid Staffordshire, and is being seen across the UK as financial constraint continues and thousands of jobs are lost.

The RCN supports Robert Francis’ recommendation regarding the role of the National Institute for Health and Care Excellence in developing staffing metrics that would then be used by the Care Quality Commission; however, we do not believe this goes far enough. The RCN is of the view, and has been for many years, that the only way to ensure safe patient care is to introduce mandatory safe staffing levels, enshrined in law.

There is a wealth of irrefutable evidence that proves the link between staffing levels and patient mortality. Put simply, the fewer nurses are on a ward, the more patients will die. As bleak as that statement sounds, it is true; and the RCN believes it is time for workforce planning in the NHS to properly recognise that fact.

The RCN believes that a number of other steps are needed to improve staffing levels across the health service, all of which can be read in this chapter.
What did Robert Francis recommend?
In his report, Robert Francis recommended:

• **22**: The National Institute for Health and Clinical Excellence should be commissioned to formulate standard procedures and practice designed to provide the practical means of compliance, and indicators by which compliance with both fundamental and enhanced standards can be measured. These measures should include both outcome and process based measures, and should as far as possible build on information already available within the system or on readily observable behaviour.

• **23**: The measures formulated by the National Institute for Health and Clinical Excellence should include measures not only of clinical outcomes, but of the suitability and competence of staff, and the culture of organisations. The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff. These tools should be created after appropriate input from specialties, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff:patient ratios.

• **93**: The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require Trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiencies in risk management, such as occurred at the Trust.

• **205**: Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.

The inquiry found that poor leadership and staffing policies resulted in a nursing workforce under increasing pressure: “The trust did not have available to it reliable figures for its nursing establishment, either in theory or in practice... What is clear is that the numbers had always been tight and declined during the period with which the inquiry is concerned.”

Reliable data management, which might have informed effective workforce planning, was severely lacking, and this was accompanied by a failure to respond to repeated concerns about staffing levels. The original Health Care Commission investigation into the failings at Mid Staffordshire NHS Foundation Trust reported that 37 per cent of the 515 incident forms submitted for three wards referred to understaffing (Francis, 2010). Staff were directly discouraged from making formal reports, and demoralised by the lack of feedback and action.

What is the RCN’s position on the recommendations?
The RCN fully supports the recommendations to develop national standards for the development, maintenance and reporting of safe staffing levels in the NHS. The RCN would like to see such standards strengthened so that safe staffing levels become a mandatory requirement. Ensuring that staffing levels do not threaten patient safety should be a mainstream requirement for regulators, commissioners and providers alike.

The work the RCN has done with the Safe Staffing Alliance has identified that when one registered nurse is allocated responsibility for the care of more than eight patients the safety risks become unacceptably high. Depending on the acuity and dependence levels of patients, the actual safe number of patients per nurse may be much lower than this. The RCN therefore believes that professional judgement and evidence-based local decision making are crucial, and would be complemented rather than undermined by mandatory staffing safeguards. While there are some who disagree, it is worth noting that many patient groups and health care leadership organisations support the need for such an approach.

The RCN also supports Francis’ themes of transparency and candour, and believes that such an approach should be adopted in relation to staffing levels. For example, a number of trusts are making ward-level staffing data publicly available. This is a positive step which the RCN believes should be adopted more widely.

What is the relevant evidence?
Inadequate staffing has been implicated in a number of serious patient safety lapses during the last decade, not only at Mid Staffordshire but also Maidstone and Tunbridge Wells NHS Trust, and Stoke Mandeville Hospital (House of
It remains a persistent issue across the NHS nursing workforce. The 2012 “state of care” report by the Care Quality Commission (CQC) indicated that 16 per cent of NHS hospitals were failing to meet the regulator’s staffing level standards (CQC, 2012); and the RCN’s own research suggests that almost 90 per cent of nursing staff do not think staffing levels are always adequate to provide safe patient care (RCN, 2013a).

The RCN Frontline First campaign monitors cuts and underinvestment in the NHS workforce. It has found that between 2010 and 2012, the NHS lost 4,028 full-time equivalent qualified nursing posts (Health and Social Care Information Centre, 2013), and has identified thousands more potentially at risk before 2015 (RCN, 2013b). Long-term workforce planning is also being neglected, with a 12.7 per cent cut in the number of commissioned nursing education places in England between 2010 and 2013 (RCN, 2013b). According to current trends in nursing supply and care demands, there could be a shortage of around 190,000 registered nurses by 2016 (Lintern, 2013). The wider European Union is facing a similar situation, with a potential shortage of 590,000 nurses by 2020 (European Commission, 2012).

What has the RCN done already in this area?

The RCN agrees with the inquiry’s conclusion that inadequate staffing levels were a key contributor to the poor quality of care at Mid Staffordshire, and has campaigned for the introduction of minimum staffing levels as an important safeguard for patients (RCN, 2012a).

The RCN attempted to get this enshrined in law through a proposed amendment to the Health and Social Care Act 2012 (RCN, 2011), and continues to campaign, working collaboratively with a number of other organisations through the Safe Staffing Alliance. The Safe Staffing Alliance has made a number of recommendations, notably that under no circumstances is it safe to have a ratio of more than eight patients per registered nurse during daytime on general acute wards, including those specialising in care for older people. The alliance also calls for ward sisters to be empowered to make day-to-day decisions on staffing and resource levels, with support from the nursing director and trust board (Safe Staffing Alliance, 2013).

The RCN’s own position draws on extensive member consultation and a comprehensive and growing body of evidence supporting the link between higher levels of nurse staffing and:

- improved patient outcomes (Pearson et al., 2006)
- improved recruitment and retention of nursing staff (Aiken et al., 2002)
- economic benefits to employers and communities (Dall et al., 2009).

Mandatory staffing levels have been introduced in a number of locations internationally, notably California and Australia. The RCN brings together evidence and opinion from across the world to assess the implementation and impact of these policies. While research into outcomes is still at an early stage, evidence from California suggests mandatory standards have resulted in significant improvements to staffing levels, skill mix and nursing hours per patient (Aiken et al., 2010). The RCN also engages with and fully supports the European Union health workforce horizon scanning joint action project to map and monitor long-term workforce demand for health care professionals.

Alongside its work to influence and inform nursing workforce policy, the RCN produces a number of professional resources to support nursing staff in evidence-based workforce planning (RCN, 2010) and makes recommendations on safe staff-patient ratios, skill mix and best practice for a number of specific settings, most recently on wards caring for older people (RCN, 2012b).

What does the RCN believe needs to happen next?

The RCN welcomed a number of proposals in the Francis report, the Government’s response and concurrent developments that have the potential to improve staffing levels through the strengthening of workforce planning and regulatory processes:

- the development of staffing-level standards and tools is an opportunity to ensure that evidence-based planning is conducted across the health care system, with compliance incorporated into the CQC’s essential standards. This should provide a clear picture for both providers and the public on what safe staffing levels look like, ideally including recommended staffing-level and skill-mix ratios. The RCN’s experience in producing a number of workforce planning resources puts it in a strong position to assist in the development of these tools
- the RCN welcomes many of the proposals in Compassion in practice, the strategy document produced by the Chief Nursing Officer for England, but believes the staffing-level plans do not go far enough. Trusts must have systems in place to monitor and publish ward-level staffing data so that issues can
be identified long before crises like Mid Staffordshire can develop. A number of trusts are beginning to publicly display ward-level planned and actual staffing levels, which the RCN believes is a positive step and should be adopted more widely.

- Workforce planning and data management must be supported by robust rostering systems. The RCN believes that effective electronic rostering can improve the efficiency of workforce deployment and rapidly respond to variations in patient demand, but has concerns about the impact on regular working patterns. The RCN is well placed to bring together suppliers, academics and nursing staff to ensure rostering systems meet the needs of both patients and staff.

- The formation of Health Education England is an opportunity to take a holistic approach to workforce planning. Workforce strategies should cover at least a five-year period and be based on careful consideration of independent supply/demand projections. The RCN will monitor the relationship between long-term national workforce planning and local workforce plans to ensure that financial pressures do not take precedence over long-term needs-based workforce planning.

References


Dall TM, Chen YJ, Seifert RF, Maddox PJ, Hogan PF (2009) The economic value of professional nursing, Medical Care, 47 (1) 97-104.


3.12 Regulation of the health care system

Summary

The Francis report dedicated a significant number of recommendations to the crucial area of regulation. The RCN supports proposals to ensure that the Care Quality Commission (CQC) and Monitor work more closely together, and also supports the use of more expert inspectors.

It is worth remembering that, while Robert Francis’ demands on the CQC and Monitor are right, both organisations will need the resources and capacity to deliver on them.

Over the years, there have been a number of changes to regulators and these have hampered the development of an effective regulatory environment. More recent changes to the various structures should be allowed time to mature. The RCN will continue to call for the improved sharing of information, more co-ordination of inspections and a stronger emphasis on quality across the system.

The RCN has undertaken a significant amount of work in this area, not least building key relationships with the CQC, to better explore what role nursing can play in the delivery of “good regulation”.
What did Robert Francis recommend?
Approximately one third of the 290 recommendations made in the inquiry report cover or relate to the role of system regulation. The single most important recommendation in relation to system regulation was to bring in a single regulator responsible for “corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts”.

The inquiry set out the expectation that the single regulator would monitor against fundamental standards (recommendation 20) that link back to common values for the service (as set out in the NHS Constitution). These fundamental standards would be developed collaboratively and be meaningful to patients and staff. They would include governance and the fitness of board members, and organisations assessed by means of a cultural barometer (recommendation 2). The standards would be monitored by looking at indicators chosen by the Care Quality Commission (CQC) (recommendation 20), with some developed by the National Institute for Health and Care Excellence (NICE) and to include staffing. Crucially, monitoring would be linked to inspections on the ground including scope for in-depth investigations (recommendation 26) and a specialist cadre of hospital inspectors (recommendation 51), as well as making better use of information already in the system (for example, in relation to complaints). Failure to comply would not be accepted; those that are found not to be meeting fundamental standards will no longer provide services, with the potential for criminal sanctions (recommendation 28). Response to failure should include immediate protective steps even if there is not yet a definitive view or evidence is incomplete, if this is in the public interest (recommendation 30). The regulator would have no role in quality improvement.

In the meantime, before the introduction of a single regulator, the inquiry suggested that there should be a template to identify the information that should be shared between regulators (recommendation 35). The inquiry also recommended that the CQC should review its processes as a whole (recommendation 55) and undertake an evaluation of how it would detect and take action if it faced the same situation as seen at Mid Staffordshire, opening that evaluation to public scrutiny (recommendation 57).

What is the RCN’s position on the recommendations?
The RCN supports:

- **intelligent regulation**: by intelligent we mean using a tailored approach with a focus on different settings of care, the use of expert inspectors on at least annual inspections and swift action when there are causes for concern. We believe all these elements feature in the many recommendations Francis made for system regulation.

- **scenario testing**: we had already asked the CQC at its engagement events, as many others did too, about checking that their systems would spot “another Mid Staffs”

- **we support specialist hospital inspectors** but we also urge the new chief inspector to ensure he draws on the existing clinical expertise within the CQC and the national clinical advisers

- **development of fundamental standards to underpin regulation**: we want the RCN’s own principles of nursing practice to form part of these

- **we support the “comply or explain” approach** – for example, that providers use appropriate tools for setting staffing levels or explain why they have not

- **equal emphasis on both quality and finance**: this includes our support for the CQC and Monitor working together and sharing information. However, the time is not right for a major reorganisation and a new “super-regulator”. Instead, the RCN believes the two organisations can build on their working relationship and ensure that balance between quality and finance works.

However, we know that the CQC is being asked to deliver a great deal and its workforce must therefore be of sufficient size and have the appropriate skills and support to deliver. We also believe that annual inspections for the majority of providers, such as hospitals, are crucial for regulation to be effective.

Monitor, too, is taking on a new set of responsibilities, and we believe that it would benefit from building in appropriate nursing input. There is a need to evaluate and learn lessons. As new system regulation and the structural changes to the NHS take shape, we call on the CQC and Monitor to set out plans to evaluate and open up the changes to public scrutiny. In time, that could also mean a move to a single regulator, but the RCN does not believe that time is now.

Over the years, there has been a number of changes to regulators. From time to time, these have hampered the
development of an effective regulatory environment. While it is clear that there needs to be a better balance between issues of quality and issues of finance in the regulatory structure, the RCN does not currently support merger of the CQC and Monitor.

**What has the RCN done already in this area?**
The RCN has taken a keen interest in system regulation because it is an important part of the broader framework needed to deliver safe, effective, high-quality compassionate care – but it is never a replacement for the responsibilities of professionals and their employers. The RCN continues to:

- respond to numerous CQC consultations, including attending and contributing via meetings, strategy days etc. We have also submitted evidence to the Health Select Committee on the CQC
- engage with our members to establish their views of the CQC, and has conducted a focus group and telephone interviews. Members bring invaluable insight into what system regulation is like on the frontline of health care
- support our members who work within the CQC
- regularly meet with the CQC, including a national clinical adviser, to discuss ongoing areas of interest. RCN nursing advisers work with the CQC on specific areas of clinical interest
- contribute to specific pieces of work. For example, RCN staff have been involved in the advisory groups for the dignity and nutrition-themed inspections. The RCN worked with the CQC on a nutrition tool used in the relevant inspections and commented on guidance developed to support staff within the CQC
- support the CQC’s efforts to bring in clinical expertise, by sharing information across our membership on the CQC’s specialist bank
- liaise with the CQC on a local level, through our regional offices, when there are concerns about quality in specific providers.

As Monitor has taken on a wider role, in addition to our ongoing work on foundation trusts, such as the foundation trust scorecard and our survey of members’ views of working within foundation trusts, we have also responded to Monitor’s engagement work and consultations as it develops its approach as the sector regulator.

The RCN has also supported linked areas of work, such as the Nuffield ratings review which contributed towards proposals for a rating system. We hosted a round-table meeting of senior practising nurses and we are an active stakeholder of the Academy of Royal Medical Colleges.

**What does the RCN believe needs to happen next?**
The RCN exists to promote standards and guidance for services and nursing practice. We believe that the focus on fundamental standards is right; these should reflect the values set out in the RCN principles of nursing practice.

We will work with the CQC on implementing and measuring these as part of “new” fundamental standards and measures to assess compliance (for example, developing tools such as the existing and jointly developed nutrition tool).

The RCN will monitor developments in systems regulation to ensure that there is an appropriate balance between attending to issues of quality and attending to issues of finance. While we accept that these are intrinsically linked, we believe that the balance of attention too often leans towards financial considerations at the expense of an organisational focus on quality and the patient.
3.13 The role of the Nursing and Midwifery Council

Summary

The RCN supports Robert Francis’ observations and recommendations in relation to the Nursing and Midwifery Council (NMC). We believe that the NMC needs to do more to explain to the public and the nursing profession what it stands for and what it intends to achieve.

We support recommendations to strengthen relationships between the NMC and the care regulators.

The NMC is working under significant pressure and needs time to find its feet. The RCN would hope to see the NMC engage in constructive dialogue with employers of nurses and midwives as we approach the development of revalidation.

The RCN has undertaken a significant amount of work with the NMC and we now look to it to focus on its core strategy, deliver financial accountability and work as quickly as possible to deliver fair and equitable decisions.

The RCN welcomes the Government’s clear commitment to press ahead with the implementation of legislative changes that will allow the NMC to update its current legislative model.
What did Robert Francis recommend?
In his report, Robert Francis recommended:

- 230: The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.

- 231: It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through co-operation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.

- 232: The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.

The central issue identified by the Francis inquiry was the largely reactive nature of the professional regulation model, for both the nursing and medical professions. The Nursing and Midwifery Council (NMC) relies on receiving complaints about the conduct or performance of individual registrants in order to investigate and take any action required. In the case of Mid Staffordshire, the NMC did not receive a larger than normal volume of complaints.

Francis noted that the statutory remit of the NMC does not allow it to investigate organisations, only individuals. However, the inquiry also found that the NMC had failed to properly define its role in the NHS and made the linked recommendation that the NMC should seek to ensure wider understanding of its role in the NHS (recommendation 230).

A key recommendation in the inquiry report is that the NMC should be able to take into account systematic concerns and proactively launch investigations if there is concern about nursing fitness to practise (recommendations 226 and 227). This approach will only be possible by working closely with the health system regulators, notably by sharing information and analysis with the Care Quality Commission (CQC) (recommendation 234).

Francis also reflected on the general criticism of NMC performance in recent years, and stressed the importance of the organisation being fit for purpose, with the right resources and administrative and leadership skills to do the job (recommendation 228).

To ensure that nurses remain fit to practise, Francis recommended that the NMC introduces a system of revalidation similar to that of the General Medical Council (recommendation 229). This might include the establishment of employment liaison officers whose function would support directors of nursing in each organisation to ensure the nursing workforce remains compliant with the NMC’s code (recommendation 232).

What is the RCN’s position on the recommendations?
The RCN supports many of the observations made by the Francis inquiry. We agree it is crucial that the professional regulators work effectively with the CQC to identify areas of concern and to take co-ordinated action.

We would support any necessary strengthening of procedures or memoranda of understanding between the regulators to enable this.

The RCN would also be pleased to see the NMC strengthen relationships with employers of registered nurses and midwives as we approach the development of revalidation. It is essential that the terms of the current regulatory framework are understood alongside the obligations of all parties to work together to protect the public.

What has the RCN done already in this area?
The RCN is committed to working with the NMC and our membership to ensure that the regulatory model for nursing is fit for purpose. We want to ensure that individual nurses are trained to the highest standards before registration and that they continue to remain competent throughout their professional lives.

The RCN does this by:

- responding to consultations on the NMC’s remit, activities and governance; for example, the Department of Health consultation on the NMC (constitutional) amendment order and the NMC’s own consultation on registration fees.
• providing written evidence to the Health Select Committee’s annual performance review of the NMC
• responding to external reviews on the legislative framework; for example, the Law Commission consultation on the future regulation of health care professionals
• engaging with our members to provide feedback from nurses and reflect their opinions on the performance of the NMC
• attending regular high-level meetings with the NMC’s leaders on professional nursing issues; for example, the NMC’s working group to discuss revalidation
• working, when required, with NMC advisers to facilitate interpretation of legislation, based on collective professional and clinical expertise.

What does the RCN believe needs to happen next?
The RCN has been a strong advocate of the need for the NMC to improve the efficiency and effectiveness of fitness-to-practise procedures, and has worked to encourage the NMC to improve its strategic planning and delivery of core functions. While we recognise that progress has been made, we are clear that significant challenges remain if the NMC is to secure the confidence of both the public and registrants.

The RCN would like to see the NMC:

• focus on core strategy
• deliver real financial accountability and demonstrate responsible use of resources
• continue to focus on meeting key targets for the improvement of fitness-to-practice procedures and reducing the historic case backlog
• continue the drive to recruit and retain the necessary staff required to deliver fitness-to-practise priorities
• work quickly to deliver an effective and proportionate system for professional revalidation.

The RCN is clear that providing an appropriate revalidation model to ensure nurses’ practice remains up to date is essential to public protection and as such should be a core function of the NMC. Any effective revalidation system must ensure that registrants continue to meet core standards of conduct and practice through continuing professional development (CPD) and is therefore dependent on employers investing in proper processes of clinical supervision and appraisal. The RCN is aware that nurses do not always receive CPD and we work hard to encourage employing organisations to protect the time and resources necessary. The Francis inquiry recommendation about establishing the post of employment liaison officer should be looked at carefully as it may support organisations in overseeing systems of annual appraisal and, ultimately, revalidation.

The RCN welcomes the Government’s clear commitment to press ahead with the implementation of legislative changes. These will allow the NMC to update its antiquated legislative model. We have provided a comprehensive report in which we set out the detail of our response to the issues raised in the Law Commission review (RCN, 2012).

References
3. The RCN’s response to the key issues in the Francis Report

3.14 Health care support workers

Summary

As is highlighted in other parts of this document, the role of health care support workers (HCSWs) has become increasingly important in the delivery of patient care.

Robert Francis delivered a number of key recommendations regarding HCSWs and the RCN strongly supports every one of them. We warmly welcome the recommendation to register (and eventually regulate) all HCSWs, and this is something that the RCN has been long been calling for. Robert Francis is also right to identify the need for a national code of conduct, as well as a common set of national standards for the training and education of HCSWs.

The RCN would be extremely disappointed if the recommendation to formally register HCSWs is not made a reality. While we understand the rhetoric that the regulation of nurses did not stop failings at Mid Staffordshire, we do not believe this is a good enough reason not to register the hundreds of thousands of HCSWs working in the UK. These individuals are delivering some of the most intimate and essential patient care in our health service and patients everywhere deserve the protection that regulation seeks to achieve.

Just as important as mandatory regulation is the delivery of standardised training and development for all HCSWs. The recommendation relating to a common set of national standards is welcome, and more needs to be done to develop a mandatory system of training for HCSWs to protect patients and ensure safe care is available to all. Additional to this is the need to recognise the importance of the mentorship of HCSWs, and the time and resources required to allow mentors to deliver good training and development.

The RCN has undertaken much work in this area, not least the development of our First Steps resource. We look forward to the publication of the Cavendish review of the education and training of HCSWs and hope the Government will heed Robert Francis’ very clear recommendations.
What did Robert Francis recommend?

- **207**: There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.
- **208**: Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a health care support worker is easily distinguishable from that of a registered nurse.
- **209**: A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship.)
- **210**: There should be a national code of conduct for healthcare support workers.
- **211**: There should be a common set of national standards for the education and training of health care support workers.
- **212**: The code of conduct, education and training standards and requirements for registration for health care support workers should be prepared and maintained by the Nursing and Midwifery Council after due consultation with all relevant stakeholders, including the Department of Health, other regulators, professional representative organisations and the public.
- **213**: Until such time as the Nursing and Midwifery Council is charged with the recommended regulatory responsibilities, the Department of Health should institute a nationwide system to protect patients and care receivers from harm. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious breach of the code of conduct or otherwise being unfit for such a post.

What is the RCN’s position on the recommendations?

The RCN has a clear position of advocating for UK-wide mandatory regulation of health care support workers (HCSWs) and so we are very pleased to endorse the above recommendations.

We agree that work needs to be done to clarify the nature of the responsibility and relationships between registered nurses and HCSWs. The public deserves to know who is caring for them and be confident that the person is competent as well as compassionate.

The RCN also believes in the delivery of a standardised system of training and development for anyone seeking to be an HCSW. Anecdotally, we know of examples where a would-be HCSW is given little more than an hour’s training before being sent to care for patients, often older people. The RCN believes this is unacceptable and immediate change is needed.

What is the relevant evidence?

HCSWs form a significant and integral part of the nursing workforce and perform fundamental and more complex aspects of nursing care under the delegation and supervision of registered practitioners. Their role has developed considerably in recent years as noted in a scoping review commissioned by the Nursing and Midwifery Council: “Health care support workers are increasingly extending their role to undertake tasks previously undertaken by registered professionals but remain an unregulated workforce” (Griffiths and Robinson, 2010).

What has the RCN done already in this area?

The RCN recognises that HCSWs and assistant practitioners (APs) are a hugely important part of the nursing team across all sectors and in every specialty. We recognise that they are often key providers of essential aspects of patient care and an important part of the nursing family. As such, membership of the RCN is open to HCSWs and APs and we now have two places on our national ruling body (RCN Council) to strengthen their contribution to policy and practice development within the RCN.

The RCN has been vocal in calling for mandatory regulation for all HCSWs since 2007 (RCN, 2007), and campaigned for this throughout the passage of the Health and Social Care Bill. This position was supported by the independent Willis Commission (Willis Commission, 2012).

A wide range of weaknesses inherent in a voluntary approach to regulation has been highlighted by the RCN (RCN, 2012a). As Francis notes: “A voluntary register has little or no advantage for the public.” The Health Select Committee (2011) commented: “The committee endorses mandatory statutory regulation of health care assistants and support workers and we believe that this is the only approach which maximises public protection.”
The RCN contributed to the development of codes and standards through Skills for Health and Skills for Care. However, throughout this work the overriding opinion of other stakeholders, not just the RCN, was that without a mandatory system of regulation it would be extremely difficult to implement these codes and standards. The RCN requested that an addendum to the final report should be made to ensure this was noted, but the request was refused. The RCN will continue to lobby for statutory, mandatory regulation for all HCSWs. A position statement on the education and training of HCSWs (RCN, 2012b) was published to provide commissioners, education providers and employers with guidance on best practice in education and training matters.

The RCN has been represented on the advisory group for the Care Quality Commission’s work into understanding the various themes that an induction programme for health care assistants and adult social care workers should cover.

The RCN met with Camilla Cavendish, who is conducting a review of care assistants, and to help inform the review responded to questions posed around recruiting the right people, education and development, career frameworks, supervision and support, and employer accountability. The importance of consistency and standardisation of good practice was highlighted, and in particular the essential nature of induction for all employees providing care for patients. The RCN position statement on training and education of HCSWs was noted (RCN, 2012b), as was the briefing paper outlining the role boundaries of support workers and registered nurses (RCN, 2012c). Several members of the RCN Health Practitioner Committee attended Cavendish focus groups, and members of the Cavendish team met with HCSW members at RCN Congress to add responses to the review’s ongoing HCSW survey.

The RCN has produced an online learning resource, First Steps, to support the induction of HCSWs. This resource covers key induction topics and cross-references to the Knowledge and Skills Framework and national occupational standards relevant for HCSWs. It refers to the RCN principles of nursing practice, which are relevant to all nursing staff, including HCSWs, and in turn links in to the “6 Cs” noted in NHS England’s (2013) Compassion in Practice implementation plans. A range of resources about accountability and delegation is available on the RCN website.

What does the RCN believe needs to happen next?

The RCN supports the recommendation that HCSWs should be easily identified and distinguishable from registered nurses. In Wales, Northern Ireland and Scotland national uniforms have been introduced to make it easier to identify different staff.

HCSW roles must be clear and all members of the team need to be aware of their level of accountability so that delegation can be appropriate and always in the best interest of the patient.

The RCN maintains the position that all HCSWs should be regulated in the interest of patient safety, and that this regulation should be mandatory. The codes and standards will not be implemented in a consistent manner unless they become a statutory requirement. The RCN does not agree with the Government’s assessment that a register would be too bureaucratic and costly an exercise, and believes there are a number of options worth exploring, including Robert Francis’s recommendations which he argued were designed “not to be resource hungry” (Lintern, 2013).

The RCN will continue to work with HCSW members to strengthen the case for a national system of accredited training, standards development and regulation.

References


Health Select Committee (2011) Nursing and midwifery annual accountability hearing with the Council; Seventh Report of Session 2010–12; Published on 26 July 2011 by authority of the House of Commons; London: The Stationery Office.


3. The RCN’s response to the key issues in the Francis Report