A new vision of nursing and midwifery

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

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

1. Introduction

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

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

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

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

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

2. Nursing as a diverse workforce

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

The culture of the organisation is central to the provision of ongoing, consistently high-quality care, which should always be at the top of the executive and non-executive boards’ agendas.

¹ W.H.O Munich Declaration 2000
In order to fulfil their responsibilities, nurse executives need the authority and ability to talk about the issues relating to the provision of excellent care, and their views must be respected and acted upon by the chief executive and other board members.

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

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

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

**Ward leadership**

The ward sister/charge nurse/team leader provides the link between management and the front line staff who personally interact with the public and patients. They are the interface between management and care delivery, and can only be effective if they have the support, the time, authority and respect necessary to competently and visibly lead their teams on the delivery of high-quality care.²

**Nursing students**

The decision has been made for graduate entry to the profession to be implemented across the UK by 2015 - meaning that there is much work to be done to encourage both school leavers and mature students to continue to enter preparation programmes for nursing. This will involve co-operation with the careers services and those who prepare applicants through courses in further education colleges and trusts.

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

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² Breaking Down Barriers; Driving up standards: The role of the Ward Sister and Charge Nurse. The Royal College of Nursing 2009
If the profession is to attract high calibre mature students, we must address problems attached to childcare, bursaries and the ‘passport’ which would enable a student to transfer from one higher education institution (HEI) to another more easily when family commitments make this necessary.

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

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

If future nursing is to deliver what is demanded of it, a number of educational benefits awarded to the medical profession should be more equitably shared. We need to explore how high-quality preceptorship, continuing professional development, clinical placements and mentorship can be made accessible to all students and qualified nurses, not just the lucky few. While the cost of such developments is significant, the investment will result in a far higher and more consistent provision of excellent nursing care.

**Nurse educators**

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

Most nurse educators work in universities where recruitment would be easier if, like for medical colleagues there was free movement of pensions between the NHS and HEI, and if those who continued to maintain practice competency through a patient care commitment were to receive the clinical lead on salary paid to similar medical lecturers.

Support should also be offered to enable these lecturers to undertake doctoral programmes, such as professional doctorates, which enable them to lecture in theory and practice at the highest possible level.

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

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

Well-trained and supported HCSWs and, increasingly, APs are core to the delivery of safe and effective care in all health care settings. 200,000 nurses
are due to retire in the next decade\textsuperscript{3}. This begs the question: where will our nursing workforce come from in the future? This is against the backdrop that many young people do not perceive nursing as a suitable career option. With an ageing population in the UK, people are living longer and developing a number of long-term conditions that will require care in the community: the challenge is to develop a suitably trained and educated nursing workforce that is able to deliver continuous quality improvements to patient care.

Nursing teams must be developed which contain an appropriate blend of skill and grade mixes, which ensures they are capable of providing high-quality care to their patients. Skill-mix design should focus on patient need, not financial restraints. An over-diluted and inappropriate skill mix may save money in the short term, but will bring added and preventable costs in the longer term to the organisation. While HCSWs and APs are essential members of the nursing team, they should be easily identifiable by patients – perhaps by wearing a standardised uniform, as has been recently introduced in Scotland and Wales.

HCSWs and APs contribute to the:

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

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

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

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

\textsuperscript{3} Peter Carter, Chief Executive and General Secretary of the RCN 2009
accessible funding streams to support the education and training of this workforce, and funded opportunities for HCSWs and APs to continue up the career pathway to undertake registered nurse training. Instead of HCSWs and APs being seen as a separate career pathway, it will be seen as integral to nursing, and a significant number of registered nurses will begin their career via this pathway. Many people will want the opportunity to step on and off the career escalator.

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

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

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

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

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

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

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

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

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

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

The term ‘clinical leadership’ needs to embrace nursing in the same way it embraces medicine. The term is frequently misused and is, in reality, a byword for ‘medical leadership’. Whenever there is a requirement to consult with clinical leaders, or to have clinical leadership representation, there is either an absence of nurses in the room, they are in a minority group, or they are present as a token gesture. Examples include membership of primary care trusts, NHS trust boards and clinical leadership positions in acute
specialties. Sadly, and to the detriment of patient care, the contribution of nurse leadership and nursing is often under valued by NHS Managers.

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

3. Nursing across specialities and contexts

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

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

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

Children and young people will increasingly have diverse needs across a range of settings, demanding nurses capable of working across settings and boundaries. Health service provision will increasingly be provided in an integrated way with and alongside social care, education and the voluntary sector. Many health care teams will be led by advanced children’s nurse practitioners and nurse consultants, with referral pathways to paediatricians who are engaged on a ‘consultancy’ basis.
Pathways for children’s and young people’s services will include acute and urgent care services, neonatal services, CYP mental health, long-term conditions and specialist services. Each pathway of care will encompass prevention, identification, assessment, interventions and long-term support. This means both basing services around the patient journey and taking a whole system approach to the commissioning, delivery and regulation of services. Children’s nurses along the pathways will increasingly prescribe, undertake clinical assessments, diagnose, interpret X-rays and diagnostic imaging, plan and evaluate treatment, discharge and provide follow-up care without reference to a medical practitioner.

**Nurses, mental health and learning disabilities**

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

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

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

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

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

Mental health nursing is well-placed to contribute to developing more personalised health care, partnerships with the independent and charitable sector, and expanded roles to meet changing health care needs and the ageing of the population in a variety of settings.
New roles such as nurse consultant, modern matron and the roles introduced in the revision of the Mental Health Act have seen mental health nursing advance to levels of more autonomous practice that will deliver improved services. Further nurse-led services will emerge which are underpinned by advances in practice, such as diagnosis and independent prescribing.

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

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

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

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

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

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

The RCN supports the call to improve the care of people with LD through the appointment of specialist LD nurses in hospitals. In the community, LD nurses provide a critical role in supporting people to improve their health and quality of life.
Nursing in the community
Transforming Community Services is an essential and ambitious direction of travel for future health services, and has profound implications for nursing. Nurses have always worked closely with people to help them improve their health and quality of life, and will continue to do so regardless of changing health patterns, health problems and new technologies. TCS further emphasises this.

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

Future nursing must focus on health inequalities, health improvement, self care, better health information for the public and the provision of excellent end of life care, all of which can take place in the community rather than the hospital. The underpinning principle being, that nurses must have the right skills and knowledge, wherever they happen to be working. The training and education of nurses has to change, so that it prepares them (on registration) to function equally competently in the community and the hospital and to work with an increasingly ageing patient group. While it is ludicrous to suggest that we will no longer need to prepare nurses for the hospital, we certainly need to seriously consider what action needs to take place to ensure that we prepare both the correct number, and appropriately educated nurses to work in the community.

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

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

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

Acute and intensive nursing can easily be provided with safety and quality in the community by those nurses who have received adequate preparation and education and who are supported in developing advanced skills. The public
need to understand their health and wellbeing does not depend upon the local hospital, but can be enhanced by having access to well-developed and comprehensive community nursing services.

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

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

1. 80% of the nursing workforce will be working with local people to improve their health, rather than working in the hospital fixing the preventable

2. pre-registration nursing courses will prepare a nurse to be able to function equally well in the community and hospital

3. local health organisations will employ public health nurses who work with colleagues to engage in community development and health improvement programmes

4. it will be normal for acutely ill patients to be cared for in their own homes

5. people will expect to die at home, receiving all necessary care and attention from appropriately prepared nurses

6. community nursing will be a popular career for talented nurses

7. community nurses will have played an enormous part in improving the health of people living in England, resulting in the safe reduction of a large number of hospital beds.

Midwifery and women’s health services
Maternity wards are often confusing places for women, especially those experiencing childbirth for the first time. Sadly, some experiences of antenatal labour and postnatal care are of poor quality. Media reports today highlight “not enough midwives, staffing levels are low and new skills are needed to work in hospitals”

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

4 RCM 2009
While hospitals are becoming less attractive place for midwives to work in, there is a positive move towards the concept of working in a poly clinic or other primary health care setting, as cited in Lord Darzi’s report.

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

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

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

**Addressing diversity and equality in nursing**

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

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

In terms of leading service design and provision, attention should be paid to encouraging people from a diverse range of backgrounds to get involved in commissioning through LINks and PPI groups; governance of foundation trusts; and seeking roles as non-executive directors.

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

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6 The Mary Seacole Leadership and Development Awards were developed out of the clear recognition that more needed to be done for black and minority ethnic (BME) nurses, health visitors and midwives in the NHS. The 2007 and 2008 awards were open to all in clinical practice in England with the
rewarding those who have made a particular contribution in that respect. At a local level, mentorship and support groups can encourage nurses from BME backgrounds to believe that they can make a difference.

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

8. Recommendations
The RCN’s key recommendations are as follows:

- Service improvement demands that commissioners focus on patient care pathways, rather than commissioning different services in different settings. Examples of such approaches where care has been significantly improved as a result, include those pertaining to the management of strokes, and heart failure.

- More could be done along the nursing career pathway to ensure a visible commitment to nurturing equality and diversity in the workforce, which can help the NHS and other employers in health and social care to comply with legislation and public policy; improve public image; and recruit and retain talented and motivated staff from BME and other backgrounds. We are particularly keen to see sustained progress in addressing inadequate representation at leadership levels from amongst BME groups.

- The development of services, according to care pathways means that the nursing workforce must have transferable skills and knowledge, and be capable of caring for patients in both the hospital and community. Nurses will be mobile, always going where their patients happen to be, rather than being fixed in one building or institution.

- Nurse educators will need to be capable of preparing a nursing workforce which is able to safely transfer from one setting to another, and always providing high-quality care. Wherever people are receiving nursing, their care will be underpinned by all the elements which

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

7 NHS Leadership Centre (2001) ‘Getting on against the odds: how black and minority nurses can progress into leadership’


9 Getting better: Using Stroke Services across the UK. Stroke Association 2009)
promote dignity, reassurance, positive health outcomes and safety. It is critical to patient safety that all nurses have an in depth understanding of the basic elements of care, eg post operative observations, nutrition and hydration, personal hygiene and record keeping.

- The 21st century nurse must have an understanding of public health and, regardless of their main place of work; promote health and equality; develop the skills and knowledge to work effectively with older people; take the right action to prevent disease and identify it at the earliest possible opportunity.

- 70% of health care is nursing, which is by far the major provider of care within the NHS and independent provider organisations. If health care organisations were committed to ensuring that nursing was well led, resourced and supported, it is likely that patients would be safe while in their care.

- It is essential for health care organisations to focus on the quality of all levels of nursing care, from fundamental and basic nursing through to specialist and advanced practice. Lives are saved and the patient experience improved when we ensure this happens, yet when finances have to be saved it is often nursing which is reduced before other disciplines. We must learn lessons from the Maidstone and Mid Staffordshire Hospital experiences.

- The highest quality care is provided at the least cost to the organisation. It is poor care which brings added financial burdens to the health care organisation. Money is not saved by reducing nursing numbers and diluting skill mix. Patient experience and health outcomes are improved through deploying adequate nurses and HCSWs at the appropriate skill mix to best meet patient needs. The RCN Ward Sister Project demonstrates the added value that well-prepared and supported ward leaders bring to patient care.

- The RCN supports the ambitions and aspirations of Transforming Community Services and is keen to work with the DH on its implementation.

- Despite the many reports and press coverage on the provision of poor nursing, the profession continues to be largely respected and trusted by the public. We must constantly reflect on how the public sees nursing, what it expects from us and how we need to adapt to meet changing expectations and needs.

The profession needs to be seen as a vibrant, though challenging career by intelligent school leavers and mature potential students.
Basically, the public wishes to ‘be safe in our hands’, reassured when, as patients they experience frightening and distressing illness. Hospitals are emotionally charged and complex organisations where patients and their families experience the very best and worst of times.

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

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

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