Royal College of Nursing
response to the Chief Nursing Officer (England) vision for nursing, midwifery and care-givers –

‘Developing a culture of compassionate care: Creating a vision for nurses, midwives and care-givers’

November 2012
With a membership of almost 400,000 registered nurses, midwives, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The RCN welcomes the opportunity to comment on this important consultation for nursing and the wider nursing family.

1. Through initial discussions with the professions, have we identified the right shared purpose for nurses, midwives and care-givers - to maximise our contribution to high quality compassionate care and excellent health and well-being outcomes for all people? Please explain your answer:

The Royal College of Nursing believes that this is the right vision – a vision which articulates a vision for high quality compassionate care and excellent health and wellbeing outcomes for all people. We would like to see the term “effective” added to the vision strapline as in “high quality, compassionate and effective care” but overall we welcome the proposed framework.

The document outlines clearly what nurses, midwives and care-givers should be striving for. However, we do have concerns that the statement is in places rather broad and as such it may be difficult to measure success, especially with regard to well-being outcomes or other behavioural indicators. It will be important to ensure that the vision is grounded and realistic; that it will be perceived by Nurses and other care givers as supportive and genuinely helpful in what is and will continue to be an incredibly demanding environment professionally, economically and practically.

In terms of the broad thrust of the vision, RCN members have expressed some concern that the emphasis in the text appears to focus on older people. The RCN believes that the vision should makes reference to the needs of all vulnerable groups – children, those with learning disabilities and mental health problems for example. This will be particularly important given that the public will have heard so much about poor care for these groups (such as the abuses at Winterborne View and the numerous concerns raised recently about safeguarding and child abuse).

The RCN is pleased to see an emphasis on the role of a motivated and supported workforce in delivering this vision. There is a wealth of evidence to connect nursing practice to high quality care and improved patient safety and patient experience. In particular, evidence points to the clear role of the nurse in preventing deterioration in patient health through rapid intervention, reducing infection, building a climate of safety, reducing costs and preventing errors in the management of medicines.\(^1\)

\(^1\) http://www.cna-nurses.ca/CNA/documents/pdf/publications/ROI_Value_Of_Nurses_FS_e.pdf
impact of adequate RN staffing is clearly understood and should be an integral part of the vision. It is important, however, to recognise that outcomes are influenced by issues such as staffing and skill mix; internal processes such as team work; safety systems and supervision; integration with other services (such as social care) and particular patterns of behaviour. These issues impact on developing quality care and achieving outcomes rather than structures and processes.

Providers, commissioners and the public should be provided with unambiguous information demonstrating how important it is to have the right skill and ‘grade’ mix along the patient care pathway to ensure maximum health gain and efficiency. It is incumbent on NHS service providers to demonstrate that they have nurse staging levels and mix of skills needed to deliver services safely. Systems and staffing metrics must be in place to allow the public and regulators (for example CQC) to see that this duty is fulfilled.

There is a body of evidence from inquiries into systemic failures at Maidstone and Tunbridge Wells NHS Trust, Mid Staffordshire NHS Foundation Trust, Stoke Mandeville Hospital, and West London Mental Health NHS Trust concerning the impact of chronic understaffing. These inquiries referred to the constant problem of understaffing, which had a negative impact on ward cleanliness, patient nutrition and safety, and staff welfare. In both cases, independent bodies made clear connections between poor staffing levels, poor quality care and inadequate patient safety.

Alongside the above, the RCN strongly believes there would be value in making reference to the health and wellbeing of the workforce, as these are now shown to have an impact on the quality of services and care to patients. The final report of the independent NHS Health & Well-being Review in 2009 (‘The Boorman Report’) found clear links between staff health and well-being and the three dimensions of service quality: patient safety, patient experience, and the effectiveness of patient care.

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2 RCN Policy Unit, Setting appropriate ward nursing staffing levels in NHS Acute Trusts, September 2006
5 Healthcare Commission (2007) Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust
Patient experience measures need to be cross-referenced with staff experience measures to highlight where organisations are failing to invest properly in an appropriately skilled and sustainable workforce.

A failure to learn from the above evidence will reduce the impact of this vision and potentially risk patient, public and staff well being in a challenging environment.

2. **What do the six values and behaviours for the professions - care, compassion, competence, communication, courage and commitment mean to you?**

To identify the meaning of each of these on behalf of our members would be an impossible task but we do believe the 6 C’s can be mapped against the RCN’s *Principles of Nursing Practice* which were developed in partnership with our members, patient groups and other professional bodies. The Principles tell us what all people can and should expect from nursing practice, whether they are colleagues, patients, or the families or carers of patients.

**Principle A**
Nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.

**Principle B**
Nurses and nursing staff take responsibility for the care they provide and answer for their own judgments and actions – they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law.

**Principle C**
Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care.

**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.
Principle F
Nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care.

Principle G
Nurses and nursing staff work closely with their own team and with other professionals, making sure patients’ care and treatment is co-ordinated, is of a high standard and has the best possible outcome.

Principle H
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.

3. What steps are needed to embed the values and behaviours - care, compassion, competence, communication, courage and commitment - into every contact and all the care we deliver?

The CNO vision will need to have an impact on a number of areas in order to embed the stated values into every contact. It must be a vision that is shared with a number of agencies and bodies (for e.g. regulators and commissioners).

There is also an urgent need to focus attention on reducing bureaucracy particularly in concerning the rise and rise of the data collection burden that is falling on frontline care givers. It would seem desirable to ensure that the implementation of the vision should rely on wherever possible on existing tools and processes – for example Nursing indicators could be included in national clinical audit and cross referenced to the 6 C’s.

Education
The RCN believes that these values and behaviours need to be embedded in all education pathways and at every level – from induction programs for care-givers through to support for advanced practitioners and beyond; from the first day at university for students to the first day in they enter the clinical area as practitioners post registration in a new job.

Recruitment of care-givers, whether onto a university course or directly into the care environment, needs to focus on attracting people with the right attributes as well as academic ability. The Six Cs and the Principles of Nursing Practice provide a framework with which to assess those attributes at recruitment and ongoing.

The Willis Commission report on pre-registration nurse education\(^{10}\) states that all people employed as care-givers, on bands 3-4 or equivalent should be trained to

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\(^{10}\) Willis Commission (2012) *Quality with Compassion: the future of nursing education*
NVQ3 or equivalent as a national minimum standard – the RCN wholeheartedly endorses that view. Given the increasing use of care givers, there is a compelling case for and substantial public interest in them becoming a regulated workforce. Many members of the public will be surprised that there is no national register of care givers with a code of practice by which they can be held to account.

**Role of employers**

These values are extremely important both in the behaviour of individuals and in organisational culture. However, the ability of any individual or team to embody these values will be influenced by the organisational factors which influence their work.

Meaningful staff engagement has been shown to produce concrete benefits within the NHS – ranging from improved patient outcomes to reduced rates of sickness absence. It is essential that staff are engaged and involved where new ways of working and behaviours are proposed. To that end the RCN believes that some thought needs to be given into the dissemination of this vision – simply to circulate around Trusts and employers will not reap the success envisaged. Nurses and care-givers on the ground need to have an opportunity to discuss how this vision will be implemented. How will teams measure and ensured these values are being adhered to? How will they even know this vision exists? Who will be responsible for implementing and monitoring in each area? In these times of economic difficulty and continuous change in the service inspiration will be needed to capture staff imagination.

One of the benefits of safe staffing levels referred to previously is that mentors would have sufficient time to spend with their students or newly qualified staff. The latest RCN/Nursing Standard survey of student nurses and midwives (2012) found that 17% of students had not spent the required 40% of their time with their mentor. 58% cited that their mentor was too busy as one of the reasons for this. Willis also recommends that “Employers must ensure that mentors have dedicated time of mentorship while universities should play their full part in training and updating mentors. Mentors must be selected for their knowledge, skills and motivation, adequately prepared; well supported and valued with a recognised status”.

A comprehensive clinical supervision framework should support the vision supported by supernumery ward/department managers. This should be further developed alongside good Human Resource policies that include appraisal and training needs assessment and also enable organisations to manage poor performance effectively, efficiently and compassionately.

**Leadership**

One of the further key elements for improving NHS efficiency and raising quality is to work in close partnership with nurse leaders. This group of leaders have shown the skills and the capacity to manage efficiencies and improve productivity in the NHS.
The RCN believes that further opportunities must be available to develop nursing leaders and to fast-track nurses to roles with a significant impact on patient care delivery. The nurse director has a key role at a strategic level and is central to achieving organisational and cultural change, with the ability to develop a comprehensive view of the patient journey and the challenges associated with it. Ward sisters, charge nurses and team leaders provide the link between management and the front line staff. 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.11

Nursing leaders’ responsibilities span patient safety, quality improvement, service delivery and workforce planning. This means they have knowledge and expertise in relation to how systems work together strategically, systematically and practically. Nursing leaders are also responsible for the development of quality improvement and assurance systems and clinical governance processes that are rooted in clinical practice and thereby integral to cost effectiveness, patient safety and public confidence.

In addition nurse leaders have a population based and health economy perspective and understanding that incorporate health prevention and education. They also have expertise and experience of working with a variety of systems including health, social care and education and with a diverse and plural range of providers.

Historically nursing leaders have had a key role in commissioning education and workforce planning. Traditional medical based planning and models contain an inherent multidisciplinary “blind spot”. Nursing and the allied health professions understand the skills and attributes of the wider health and social care team which will be crucial to commissioning integrated and outcome focused care packages. Nursing leaders are in a pivotal and unique position to support service and education commissioning decision making and lead and manage the transition and transformation of whole systems. Nursing leaders are frequently the proprietor of organisational memory and work at the interface of health systems regulators.

In summary, the RCN feels that if we want nurses, midwives and care-givers to embed the values and behaviours it is important that nurses, midwives and care-givers feel the same values and behaviours directed towards them. Specifically that:

- employers are seen to recognise and care for all their staff;
- they are treated with compassion in recognition of the emotional aspect of caring for people and therefore have time for clinical supervision and reflective practice;
- they have access to training and development opportunities to ensure they maintain and develop their competencies;

11 Breaking Down Barriers; Driving up standards: The role of the Ward Sister and Charge Nurse. The Royal College of Nursing 2009
The employer has a range of modern and responsive HR policies which support improvement and which can also act decisively and compassionately to deal with anyone who consistently fails to deliver compassionate and competent care;

- Communication is effective and is understood especially with regard to change management practices.
- Staff can work in a culture where they are encouraged to speak up – whether it be about innovation in practice or about a concern regarding care and that courage is rewarded rather than penalised; and
- the resources are there to make all the above happen.

4. **Will a focus by nurses, midwives and care-givers on the six priority areas we have identified deliver the vision and the shared purpose? Is anything missing? Please explain your answer.**

The six priority areas are clear and section three sets out how this can be delivered. A key issue will be whether the resources and time are identified to ensure this happens. For instance instigating the supervisory status of the ward or team leader has a resource implications but is pivotal in developing the appropriate ward culture. Assessing and implementation of safe staffing levels is unlikely to be cost neutral but over the longer term will provide social, economic and staff savings.

5. **What national and local initiatives are you aware of that support the six priority areas? Please provide brief details**

   *This is Nursing*

   The Royal College of Nursing’s initiative “This is nursing” seeks to help professionals and the public learn more about the reality of modern-day nursing and the skills required to be part of this profession.

   It also explores the immense challenges that face nursing staff and explores how we can overcome these challenges, for the good of patients across the UK.\(^{12}\) *This is nursing* is a really positive initiative, aimed at both members and the public, designed to promote the profession and highlight the dedication, knowledge and skills needed to be a modern day nurse. The initiative contains seven key work streams, led by members and staff of the RCN. They are:

   - paperwork and administration
   - staffing levels – including the care of older people
   - nurse education
   - professional attitudes and behaviours
   - leadership
   - training and regulation of HCAs

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\(^{12}\) [http://thisisnursing.rcn.org.uk/](http://thisisnursing.rcn.org.uk/)
In particular the report resonates with work being undertaken as part of the professional attitudes and behaviours work stream. A key issue is the environment of care, the organisational culture and leadership at all levels of the service. Work in progress will assist with the identification of protective factors enabling retention of professional attitudes and behaviours even in the face of adversity or poor context of care provision.

The RCN has never sought to shy away from the cases of poor care when they exist including examples where the public and others have felt that the 6 C’s were not adhered to. However, when poor care does exist, there are often systemic reasons behind it. This is nursing will expose and explore what these factors are, how they can be tackled and how the public can be reassured that nursing will always be there for them.

RCN collaboration with NICE

The RCN is a joint publication partner of NICE quality standards and currently holds the chair of the Management Board of the National Clinical Guidance Centre of NICE. We assist them in accessing Nursing expertise to develop guidelines and quality standards (essential for provision of evidence, relevance and utility). We have contributed to 349 outputs in 2011 and over 3000 nurses are involved, reviewing draft documents, as members of guideline development groups, as clinical specialists to appraisal committees etc.

RCN work on patient safety and clinical human factors

The RCN has collaborated with members of the Clinical Human Factors Group in delivering a report on the role of clinical human factors as a framework for education and training on patient safety issues. We know that this work was received by the Medical Director at the Department of Health and that a group has been set up to review the implications of the report led by Professor Sir Michael Rawlins. It is crucial that the momentum to establish multidisciplinary education in this field is progressed. The RCN is also working with the Health Foundation to deliver a patient safety network in 2013. This work resonates with the action areas identified by the vision statement.

Other RCN initiatives

The RCN worked with the DH and other organisations to develop and raise awareness of the Principles of Nursing Practice as referred to above. You can find out more by visiting www.rcn.org.uk/development/practice/principles.

The RCN has developed a range of effective leadership programmes such as the Clinical Leadership Programme to support the development of the role of the ward and team leader to directly influence patient experience. At a strategic level the Political leadership programme has supported Director and Assistant Directors of
Nursing to become more effective in the board room in their role of advocate for quality care.

The RCN has developed a range of interactive online resources on the learning zone for registered and non registered members. For example, the RCN ‘First Steps’ resource is an online induction package specifically for Health Care Assistants. First Steps is endorsed by Skills for Health. The programme includes modules on communication, accountability, the delivery of safe effective care and consent.

The RCN has also been pleased to support and have input into a range of other initiatives such as:

- Energise for Excellence, NHS Institute for Innovation and Improvement embraces a number of key programmes that nurses and midwives can use to drive both quality improvement and cost reduction. Under the Energise for Excellence umbrella NHSII+I have gathered an array of tools, approaches and measures that will help nurses and midwives decide which priorities they want to focus on so that they can be confident that their patients receive the best possible care.

- The High Impact Actions for Nursing and Midwifery from the NHS Institute for Innovation and Improvement were developed following a ‘call for action’ which asked frontline staff to submit examples of high quality and cost effective care that, if adopted widely across the NHS, would make a transformational difference.

6. How do we strengthen working between the health and social care sector in the six priority areas? Please provide brief details.

The RCN believes that a “whole systems” approach to integrated care must be taken if the ambition is to be realised. In other words, it would be important to address commissioning, outcome measures, regulation, the national tariff and payment systems and workforce planning in order to achieve closer integration, and not just reform organisational structures.13 The RCN supports an approach to pricing that incentivises the delivery of integrated care (for examples the currencies underpinning pricing which will be decided jointly with the National Commissioning Board) and which are flexible enough to respond to innovation.

In a recently submitted response to Monitor on commissioned work on enablers and barriers to integrated care14, we noted that integrated care must be centred on the patient and not on the institutions concerned. Patients want access to seamless and timely care – for example they do not want to have to repeat their histories,

experience delays in accessing care, or have to become experts in navigating the system\(^\text{15}\)  

We have commented previously on this issue (See for example the RCNs response to the Future Forum in 2011\(^\text{16}\)) but the challenges of integration are not insignificant. However we have found that many of our members are working to achieve integration now in the interests of their patients despite these challenges. To deliver integrated care, our members tell us that they are challenged by multiple systemic barriers that they must overcome in order to deliver integrated care across health and social care. For instance, the eligibility assessment processes across the care systems are complex and confusing and ultimately time-consuming and duplicative. Nurses who work in health care feel burdened by the administration involved in assessing who pays.\(^\text{17}\) Disputes over who pays for care too often result in delayed transfers of care.

Nursing staff have the frustrating, upsetting task of managing and delivering the care of patients receiving inappropriate care or care in the wrong setting. Again too often, nursing staff experience the frustration of seeing a healthy patient discharged into community care, only to see them readmitted into the acute setting weeks down the line owing to the absence of appropriate community care – the so-called ‘revolving door’.

The differences in how care is paid for in social and health care is a root cause for the problems service users experience in receiving care that is not joined up, appropriate or cost-effective. It is critical that Government shows leadership to resolve the long overdue and urgent issue of social care funding system reform. They must also ensure that the review of the social care eligibility criteria, that is planned if the Draft Care and Support Bill is passed, considers how to overcome the ‘assessment industry’\(^\text{18}\) The RCN would also like the review to consider the application of national eligibility criteria for continuing health care and thereby deliver a continuum of care assessment, which should help deliver a smoother patient journey.

In addition to the six priority areas, nursing staff also demonstrate innovation to improve integrated care deliver. They have played leading roles in establishing a number of working practices to help deliver integrated care such as discharge planning, single assessment and multidisciplinary team working meetings and

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They have recognised the importance of early intervention, regular reassessment and adaptability and have incorporated them into their working approaches. There is much best practice across the country within nursing teams, which should be shared and implemented on a nation-wide basis.

Some positive action areas for this might include:

- Collaborative working with the care sector - shared budget, joint training and development
- Clarity re roles and responsibilities.
- Clear shared vision about working with clients and their family.
- Using managers from either setting in decision making to increase trust between agencies.
- Work together from outset and with patient groups to design services where people and their carers are actively involved.
- Work together and share information (within data protection) so people do not have to repeat their story - use client held records so clients have control not the professionals – and everyone uses the same records consecutively not just filling in own bit.
- Joint training for all care-givers and managers to facilitate understanding of each sector.
- Joint training for public health professionals and nurses, midwives and care-givers regarding health promotion and difficult conversations.
- Share existing metric systems and use to develop a shared tool.
- Look for opportunities for joint training for leadership and management development.
- Explore shadowing opportunities so leaders from health and the care sector gain better insight in to how the other sector works.
- Attend joint conferences and promote networking opportunities for managers and operational staff.
- Joint recruitment and selection processes and appointments where possible.
- Actively work to develop a culture of compassionate care
- Registration of all care-givers (health and care sector)
- Mandatory training for all non registered care-givers
- Supervision of practice for all staff not just registered staff.

7. Are there any obstacles to delivering the vision and embedding the values and behaviours? What would you want to see in place to address these? Please explain your answer.

One of the significant obstacles to delivering this vision is the current organisational, economic and social context in which care-givers are currently working.

The NHS reforms as outlined in the Health and Social Care Act have caused immense disruption and led to a significant number of staff experiencing insecurity, job changes and redundancy. We have previously argued that aspects of the reforms could lead to an increasingly fragmented healthcare landscape.

The RCN has a number of serious concerns about the practical impact of fragmentation on the NHS, including the potential for greater health inequalities and unexplained variations in service; a reduction in collaboration and sharing of good practice across NHS-funded services; and a risk to long term sustainability.

In terms of the funding for the NHS, the RCN acknowledges and supports the commitment that the Government has made to ring-fence and increase the ‘real terms’ NHS budget in the next few years. However, demand on the resources of the NHS continues to grow. The ‘Nicholson challenge’ means that NHS staff have been tasked with finding efficiency savings of £20billion over the next four years and supporting reductions in management costs of 45%. The RCN believes these conditions will lead to a sharp decline in NHS staff morale, evidence of which can already be seen20.

Despite reassurances from Government that the frontline will be protected, the RCN’s Frontline First campaign has demonstrated that cuts are already a reality on the ground21. This campaign empowers nurses to speak out about the cuts that will impact on patient care, expose where they see waste and highlight innovations and new ideas. History has shown that at times of financial pressures, for example during the 2006 deficit crisis, NHS trusts often look towards reducing frontline staffing levels as a way of reducing costs. The RCN is deeply concerned that adding more burdens to an already stretched NHS by pushing through costly reforms will result in intolerable pressures and adversely affect the safe and effective delivery of frontline services.

Of particular concern is the ongoing weakness of data to underpin commissioning and decommissioning decisions. We have been offered an insight into the information system being piloted by the NHS Trust Development Authority. We welcome this “lens on quality” and the proposal by the National Quality Board to convene Quality Surveillance Groups to share information and intelligence about quality (Quality in the new healthcare system - maintaining and improving quality from April 2013 - A draft report from the National Quality Board).

Computers speed the process of information handling, but they don't tell us what the information means or how to communicate its meaning to decision makers. These

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20 http://www.bjhcim.co.uk/news/2010/n1007028.htm
21 http://frontlinefirst.rcn.org.uk/
skills are not intuitive; they rely largely on analysis and presentation skills that must be learned not just by nurses but by staff across healthcare organisations. A shared understanding of these metrics, including workforce assurance data, will be essential. All learning and improvement comes from action and sophisticated metrics are not a proxy for learning.

Effective workforce planning in the NHS also depends on the availability of up-to-date, high-quality data and intelligence. We have however repeatedly raised concerns about the remit and capacity of the Centre for Workforce Intelligence and the related emerging workforce and education planning structures around the NHS.

Our concerns are shared by the Health Select Committee on Education, training and workforce planning who reported its concerns earlier this year about the lack of “...clear contractual obligations on all providers of NHS-funded services to provide full, timely and accurate workforce data”. They go on to assert that “Innovation in skill mix and clinical roles is crucial to achieving a more efficient and flexible workforce—but it is important for policy to be grounded on solid evidence”22.

In summary, the RCN believes that although important, addressing the personal attributes of individual staff alone is not enough to achieve this vision. Organisational culture, the stability of wider funding and commissioning systems, and the contribution of other staff who manage them have an important part to play in achieving the vision.

8. Are the terms ‘people we care for’ and ‘care-givers’ helpful to use in this context, or are there alternatives?

Given the difficulty all organisations have in describing this section of the work-force effectively and easily and with the plethora of titles used, the RCN feels that the term ‘care-giver’ at least acknowledges the role that is carried out by this group of staff. It is a useful term although there is potential for confusion with regards the caring roles of family members, volunteers and others.

The term ‘people we care for’ embraces the client group without the need for multiple terms and perhaps reminds us continuously that nurses, midwives, and other health care workers are here to care for the public. However in using this term, we should also ensure we maintain a focus on the changing relationship with patients and the public in which issues like self care and shared decision making are increasingly important.

Royal College of Nursing
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