

Response to the

NHS White Paper: 'Equity and Excellence: Liberating the NHS' (England)

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Introduction

The Royal College of Nursing (RCN) is the UK's largest professional association and trade union for nurses, including midwives and health visitors, with over 400,000 members. The RCN works locally, nationally and internationally to promote high standards of care and the interests of patients and nurses, and of nursing as a profession.

The RCN wholeheartedly supports the founding principles of the National Health Service (NHS) – namely that it should be universal, provided free at the point of delivery, based on clinical need and not ability to pay, and financed through taxation.

The RCN welcomes the opportunity to respond to the NHS White Paper. The principles on which the proposed reforms are based – placing patients at the heart of the NHS, focusing on clinical outcomes and empowering health professionals – are both welcome and supported by the RCN. The RCN's key concern is whether the policies outlined in the white paper will create a health service which is both sustainable and fit for purpose to meet the challenges of the future.

Assurances required by the RCN on the NHS White Paper

The RCN believes there are a number of assurances which the Government must provide in order to ensure that the proposed reforms will work in practice to deliver a health service which is sustainable and fit for purpose.

NHS principles

The proposed reforms must support the founding principles of the NHS, namely that it should be universal, provided free at the point of delivery, based on clinical need and not ability to pay, and financed through taxation.

National pay

The RCN opposes moves away from national pay arrangements or the undermining of the Agenda for Change package.

Pensions

NHS pensions must be protected and portable. All staff delivering NHS services must be guaranteed access to the NHS pension scheme.

Nursing leadership

Existing nursing leadership expertise and skills must be transferred to new health and social care organisations. Capacity for further growth and development must be supported at all levels across the healthcare system.

Education and training

There must be national oversight of nursing education and mandatory training. Planning must take into account the need to integrate and align the commissioning of nursing education and patient services; covering all settings and sectors and both the medical and non medical workforce.

Commissioning

Nursing must be represented at a senior level in general practice commissioning consortia and on the NHS Independent Commissioning Board. Nursing expertise must also be recognised and utilised at all levels of the commissioning process.

Public and patient involvement and engagement

There must be full engagement and consultation with patient and service-user groups, and the wider general public; and the reforms must gain demonstrable support from both before being introduced.

Outcomes framework

The nursing contribution to the NHS Outcomes Framework must be explicitly recognised.

Workforce planning

There must be robust mechanisms in place to ensure the nursing workforce is sustainable and fit for purpose. This should include a mechanism for national oversight and integration between medical and non-medical workforce planning.

Pilots and phasing

Structural reforms should be piloted and publicly evaluated. Reforms should only be phased in if evaluation proves that they are successful.

Political accountability

There must be clear mechanisms by which the tax payer can hold ministers as well as those responsible for commissioning, delivering and overseeing care, accountable for the NHS funded health and social care services.

Health inequalities

To prevent the widening of health inequalities, there must be clear mechanisms in place to monitor and address unacceptable variations in service quality/access to services.

Freeing NHS providers

The Government must set out a blueprint for a system of effective checks and balances designed to provide for a level playing field for providers and commissioners, and prevent the fragmentation of healthcare in England. The system must be developed to work for the whole country, providing guaranteed standards of sustainable, safe, high quality and efficient healthcare for all patients throughout the country.

Co-operation and competition

The Government must demonstrate how it will ensure that a fragmentation of service provision does not become a barrier to collaboration and the sharing of information, knowledge and best practice.

Social enterprise

Staff must take a positive decision to work in a social enterprise, following comprehensive engagement and a staff ballot. All staff delivering NHS services must have guaranteed access to the NHS pension scheme.

Regulation

The Government must demonstrate that there will be adequate regulation to safeguard the quality and safety of patient care. Providers must be able to demonstrate that nurse staffing is sufficient relative to the needs of the patients/clients they serve. There must be a balance between the emphasis on economic regulation of the health and social care service and the quality of care delivered.

Systems management

The Government must demonstrate how it will manage the risks associated with system reform and ensure that NHS funded health and social care commissioners, provider organisations and regulators work effectively together to maintain the delivery of a sustainable, safe, high quality and efficient service. It must also be clear how the transition costs of reorganisation will be met.

The Health Bill

The team responsible for the forthcoming Health Bill should include and be supported by advisers from across the nursing profession.

Overview of the RCN's response to the NHS White Paper

Too much, too soon, and too little evidence?

When the then shadow Secretary of State for Health Andrew Lansley visited RCN Congress in April 2010, he promised to end the continual cycle of NHS re-organisations¹. Yet the proposals set out in this White Paper will open the door to a wholesale restructure of the NHS, within timescales which are highly ambitious and fail to provide appropriate risk management mechanisms. For example, the deadlines for all GP consortia to take full financial responsibility for commissioning by 2013 and for all NHS trusts to become foundation trusts by 2013/14 appear to be overly ambitious, and would require substantial investment from an already over-stretched NHS.

There is also little evidence that the proposals set out will work in the UK context, in particular the underlying assumption that more competition will deliver greater value for money. It is certain, however, that implementing structural reforms will cost a significant amount of money (estimated at £2-3 billion²), but cannot guarantee a clear benefit will be delivered. Ensuring long term sustainability must be at the heart of system reform and the RCN believes the scale and speed of the reforms currently proposed may not meet this requirement.

Acknowledge where the NHS works well

The RCN does not believe that the NHS as it currently stands is 'broken'. The NHS has made significant improvements in recent years³ and the UK ranks highly in international comparisons of health care systems⁴. This has been evidenced by the sustained rise in patient satisfaction levels and positive patient outcomes. Evidence continues to emerge of the success of some PCTs in demonstrating progress and improvement in world class commissioning scores⁵ and in delivering on local health priorities⁶. The RCN accepts that there are areas in which the NHS must strive to improve, however, where NHS organisations and staff are performing well, this should be acknowledged and built on.

Lack of detail in the proposals

The principles driving the White Paper – placing patients at the heart of the NHS, focusing on clinical outcomes and empowering health professionals – are commendable and welcome. However, the proposals that sit behind these principles are lacking in essential detail about how the changes will work in practice and fail to recognise the vital contribution of the nursing profession. At the RCN's 2010 Congress, the then Shadow Secretary of State for Health told nurses that “we have to involve you, empower you”, yet nurses are all but invisible within the White Paper.

The lack of detail is notable throughout the proposals. For example, it is not clear what the professional

1 Andrew Lansley MP's speech to RCN Congress, 28th April 2010

2 Walsh K, British Medical Journal (2010) ;341:c3843

3 http://www.kingsfund.org.uk/publications/a_highperforming_nh.html

4 http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf although there are areas where there could be further improvements
http://www.oecd.org/document/38/0,3343,en_2649_33929_44220582_1_1_1_1,00.html

5 <http://www.hsj.co.uk/Journals/2/Files/2010/8/11/World%20class%20commissioning%20league%20tabl1.pdf>

6 Commissioning in the new world: an analysis of the impact of prioritisation on quality, expenditure and outcomes in the health service (2010) Health Mandate

make-up of general practice consortia will consist of and how we can ensure that in allowing local areas greater freedoms, we guard against unacceptable variations in service. There is also no detail on how the risks associated with system reform will be managed. In his letter to NHS managers following the publication of the White Paper, the Chief Executive of the NHS, Sir David Nicholson, said there was “a significant risk, during this transition, of a loss of focus on quality, financial and performance disciplines as organisations and individuals go through change”. This concern does not appear to be backed up by an overall risk assessment or risk management strategy commensurate with the fundamental changes proposed.⁷

There must be a thorough risk assessment before any transition process commences and robust plans developed to prepare and support the workforce to meet the proposed changes.

The need for pilots, phasing and evaluation

In order to manage the risks posed by structural reforms on this scale, the RCN urges that they be piloted, and then fully and transparently evaluated. Only if pilots prove successful should the reforms be rolled out. The RCN has made similar criticisms of the previous Government for failing to pilot reforms. This Government must learn the lessons of past reform in the NHS and ensure that the restructuring is implemented within a phased approach and to a more realistic timetable. This is the only way that the sustainability of the healthcare system can be protected.

The RCN’s Frontline First campaign

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. In the context of a national economy emerging from recession, NHS staff have been tasked with finding efficiency savings of £20 billion 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 seen⁸.

The RCN’s Frontline First campaign has demonstrated that cuts are already a reality on the ground⁹. 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.

The nursing contribution to society

Nurses provide an invaluable contribution towards the health and wellbeing of the population. From birth to death, and across care pathways, they provide care and support to help individuals and communities achieve the best possible health and take control of their lives. This ranges from the nurses and health visitors who support early years development by providing targeted interventions (for example through the

⁷ Letter from NHS Chief Executive Sir David Nicholson to the chief executive community setting out plans to lead the implementation of Liberating the NHS, 13th July 2010

⁸ <http://www.bjhcim.co.uk/news/2010/n1007028.htm>

⁹ <http://frontlinefirst.rcn.org.uk/>

Family Nurse Partnership programme), to specialist nurses who provide care and intervention at specific times of need or help with the management of long term conditions such as dementia or cancer.

The nursing contribution to patient outcomes

The RCN supports the focus on improving clinical patient outcomes. 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 medicines¹⁰ which leads to the delivery of seamless and holistic care.

Commissioning

In reality, the shift from a target driven to an outcomes driven NHS cannot happen without nurses. The profession must therefore be involved at every stage and level of the design, commissioning and implementation of services. Nurses have a unique perspective on delivering care and understanding the need of patients. As such, nurses have an invaluable insight into the practical issues of service delivery, including advice on value for money, efficiency, and effective and quality care provision. They help patients to navigate the system and are able to assess future care demands. Nurses are also best placed to understand the training and development needs of the nursing profession. **No single profession can have sole responsibility for commissioning services and if the appropriate range and mix of health and social care professionals are not involved in the commissioning process, new models will fail.**

Safe staffing

There is a wealth of evidence pointing to the positive association between the number of nursing staff deployed and the quality and safety of the care delivered to patients¹¹. Where there have been major breakdowns in patient care such as occurred at Mid Staffordshire Foundation Trust, failure to ensure adequate staffing has been a central cause. The RCN believes that provider, commissioner and regulator organisations must all commit to monitor staffing levels more closely. High level indicators should be employed to oversee organisations' ability to meet the agreed nursing staff establishment and to monitor registered nurse and healthcare support workers skill mix.

Nurse/patient relationship

Nurses will always seek to use their clinical judgement to make the best decisions on behalf of patients as well as to empower and enable patients to make their own decisions. The proposed reforms seek to empower clinicians with both the autonomy and the budget to shape NHS-funded services. However, there are significant concerns that these reforms will put clinicians in a difficult position if and when cuts are made to those services, and that they will be perceived as the rationers of patient care. We are concerned that the enhanced role of Monitor as the financial regulator across NHS-funded services could place too

10 http://www.cna-nurses.ca/CNA/documents/pdf/publications/ROI_Value_Of_Nurses_FS_e.pdf

11 Kane, R, et al (2007) *The Association of Registered Nurse Staffing Levels and Patient Outcomes: Systematic Review and Meta-Analysis*. Medical Care, 2007. 45(12): p. 1195-1204;

'RN+RN = better care. What do we know about the association between Registered Nurse staffing levels and patient outcomes?' Policy Plus. Issue 20 September 2009. National Nursing Research unit. Kings College London;

Aiken L, et al (2010) *Implications of the California Nurse Staffing Mandate for Other States*. Health Services Research. Early View (online). April 2010.

heavy an emphasis on financial considerations. The RCN believes there must be the right balance between financial, and clinical considerations.

Today's nursing leaders

Evidence demonstrates the relationship between nursing practice and patient outcomes. In order to ensure the nursing workforce is ready to rise to the challenge set out in the White Paper, strong leadership is needed across the board in NHS organisations and service providers. The NHS needs the skills, knowledge and experience of senior nurses currently working across the system – whether in existing strategic health authorities (SHAs) and primary care trusts (PCTs) or in individual provider organisations. Any loss of vital nursing leadership will jeopardise the success of the proposals. From the point of care delivery to where strategic decisions are taken there should be clear lines of accountability upwards and authority downwards to support the delivery of high quality patient care.

Nursing leaders' vital contribution to system effectiveness, managing risk and making change

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 therefore integral to cost effectiveness, patient safety and public confidence.

In addition, nurse leaders have a population based and health economy perspective and understanding that incorporates 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 models contain an inherent multidisciplinary "blind spot". Nursing and the allied health profession 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 unique position to support service and education commissioning decision making and lead and manage the transition and transformation of whole systems.

Nursing leaders play a pivotal role in helping to close the gaps between hospital and community and health and social care thereby ensuring the delivery of integrated and seamless care to patients.

Workforce wellbeing

Nursing is the biggest professional group delivering frontline care in the NHS and as such is the backbone upon which the delivery of improved patient outcomes, as well as increased productivity and efficiency, rests. We have clear evidence that staff health and wellbeing is critical to the delivery of improved outcomes, with the Boorman Review demonstrating that organisations which prioritise staff health and wellbeing deliver improved patient satisfaction, stronger quality scores, higher levels of staff retention and lower rates of sickness absence¹².

¹² Boorman et al (2009) *NHS Health and Wellbeing: Final Report*

Training and continued professional development

The vital contribution of nursing to delivering the ambitions for improved patient outcomes underlines the importance of supporting nursing clinical practice. As noted above, the Boorman Review demonstrates the link between staff wellbeing and motivation and patient outcomes. The RCN recognises the legitimate role for employer organisations in the education and training of the nursing workforce. However, the RCN believes there must be a national oversight function to ensure that current and future nurses have the right skills and competencies to continually deliver the highest quality and most efficient patient care. Ensuring that the workforce is fit for purpose requires the explicit acknowledgment and involvement of key professional bodies such as the NMC and Council of Deans alongside employers and professional representative organisations.

National pay and pensions protection

It is fundamental to the stability of the NHS-funded workforce, and to patient outcomes, that there is confidence in relation to pay and pensions. The RCN believes that pension security and a national pay system provides staff with the required confidence during periods of transition and fiscal challenge. The key drivers for introducing the national pay framework remain: equal pay (the NHS in the period preceding the implementation of Agenda for Change faced the prospect of substantial claims); recruitment and retention of staff; improving local flexibility; and removing barriers to change. A drive to local pay will prove to be expensive in terms of transactional costs and it is very unlikely to deliver any greater benefits to individual employers. Indeed, a drive towards local pay will not only reintroduce the risk of equal pay claims, but it is likely to take financial and management resources away from a focus on improving frontline clinical services.

Workforce planning

The RCN acknowledges that workforce planning is complex and not an exact science. However, in order to prevent a repeat of the boom and bust patterns of the past, there must be national oversight of workforce planning. If workforce planning is relegated solely to local organisations (who do not have experience of undertaking this role) there is a risk that, in the future, there will not be a nursing workforce fit for purpose and able to meet the needs of the population. The chronic lack of health visitors, currently singled out by the Government as an area for urgent action, provides a stark warning for the future. The community workforce is ageing and it is essential that it is revitalised in order to meet the challenges of the future and achieve the ambition to move care closer to home. This, and other workforce planning challenges, requires concerted action and responsibility at a national level.

RCN principles

When considering the proposals contained in this White Paper on the future direction of the NHS, the RCN is informed by a set of principles which demonstrate our core values (the RCN principles are attached to this response at Appendix 1). They are based around the themes of quality, accountability, equality and partnership. The RCN believes that they must form the basis for the design and delivery of health and social care services.

Fragmentation

The proposals set out in this White Paper to increase the scope for competition within healthcare delivery are untested in the UK context and introduce substantial elements of risk to the core operations of NHS-funded health and social care. The RCN questions the assumption that greater competition between providers is the only vehicle to deliver greater choice. The proposals also operate under the assumption that lots of new providers will step in, and it is not clear what the implications will be if this is not the case. The RCN is also concerned that there is a lack of systems management and regulatory oversight governing the proposals. It appears that an adequate failure regime has not been thought through, resulting in potentially catastrophic consequences for patient services and healthcare staff. 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.

Collaboration and sharing good practice across NHS-funded services

The RCN believes that the NHS is more than just a brand. Though vast, it is an organisation with a cohesive and unifying ethos and sense of purpose. The NHS Constitution affirms this, placing on staff the responsibility to “aim to maintain the highest standards of care and service, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole.”¹³ The proposed reforms, if fully realised, will fragment the present service into many different and competing services. Bodies such as the National Patient Safety Agency and the NHS Institute for Innovation and Improvement, which helped to foster the sharing of information and good practice have been abolished. The RCN is concerned about how collaboration and the sharing of information, knowledge and best practice across an increasingly competitive health and social care market will be supported.

Freeing NHS providers

The White Paper proposals appear in places to blur common understanding of the differences between foundation trusts, social enterprises and employee-owned (mutual) organisations. Social enterprises are a distinct legal entity that should not be confused with that of foundation trusts or community foundation trusts. The RCN also notes that not all social enterprise organisations will be based on an employee-owned model.

The RCN has always taken the approach that foundation trusts and social enterprises should be considered on a case by case basis, and that new or changed organisations must meet local requirements. However, the current proposals appear to set out a blanket policy of forcing changes on providers that may be neither wanted nor appropriate. NHS trusts should only seek to become foundation trusts, with all the freedoms they encompass, if they meet the needs of all local stakeholders. Equally, the social enterprise model is not a panacea and social enterprise organisations will only be appropriate in certain circumstances – for example when staff are fully consulted on the proposals, when it is guaranteed that the new organisation will be sustainable in the long term and when existing NHS terms and conditions for staff are not undermined.

13 <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx>

Staff engagement

Meaningful staff engagement has been shown to produce concrete benefits within the NHS – ranging from improved patient outcomes to reduced rates of sickness absence¹⁴. It is essential that staff are engaged and involved where changes are proposed to their organisation or service area. For example, the vision for a vibrant social enterprise sector will only be realised if the staff involved support the changes.

More generally the proposed changes will require a change in culture. This must be recognised and plans developed to support this.

Addressing inequalities

There is a wealth of evidence which demonstrates that whilst health outcomes are improving across the board, there continues to be a health gap between disadvantaged groups and communities and the overall population. The RCN is committed to eliminating this unacceptable gap and addressing the social determinants of health which contribute to health inequalities. The RCN believes there is considerable risk attached to insisting on flexible local implementation of the White Paper reforms proposed, including that it could result in the development of unacceptable local variations in access to service or service quality, which could exacerbate health inequalities. The mechanisms that would be employed to make sure this risk is monitored are not clear and neither is how problems would be addressed should they arise.

Political accountability

The NHS core principles dictate that the NHS is funded by taxation. It must therefore be clear how those responsible for commissioning, delivering and overseeing NHS-funded care are answerable to the people who pay for and use health and social care services. This includes the new commissioning consortia and Independent Commissioning Board, providers such as foundation trusts or social enterprise organisations and also the Secretary of State for Health.

The RCN is concerned that the scarcity of detail in the current proposals means that it is necessary to take it on good faith alone that the new general practice commissioning consortia and Independent Board will be governed in a way that is transparent and accountable. There must be clear mechanisms for how these bodies will conduct their business and how they will engage with and be accountable to the communities they serve locally, and to the tax payer nationally. The RCN also has concerns about where ministerial accountability for the health service lies. There must be clarity about the stage at which ministers will act in the event of variations at a local level. Patients and the public will demand and have a right to know where accountability lies.

¹⁴ See *NHS Mutual: engaging staff and aligning incentives to achieve higher levels of performance* (2009) Nuffield Trust

Consultation process and participation

The RCN used a number of methods to engage with its members and other stakeholders on the White Paper during the Government's consultation process that started on 12th July and closed on 5th October 2010. This included the following.

- A **dedicated section on the RCN web** site was established to provide a series of resources for members to engage with the consultation.
- As part of the consultation with RCN members, a **factual briefing** of the key themes in the NHS White Paper was provided which highlighted some of the key questions for nurses and nursing for members to consider.
- During the engagement process an **email was sent to all members** encouraging them to participate and send their comments to the RCN via a dedicated email address. Members were invited to take part in an **online member survey on the White Paper**. The results of which are included throughout this response document.
- A **short film** on the RCN website outlined the main issues and encouraged members to get involved. The film was also sent to members together with the online member survey.
- A **powerpoint presentation** was provided on the RCN web site for discussions by activists, RCN forums, regional boards and other groups of members. This prompted a number of local discussion events, for example an engagement event was organised by the RCN Cambridge Branch.
- The RCN used the **media** to outline the RCN's initial response to the White Paper and to raise awareness of the consultation. There was a **series of nursing press articles, features and news reviews** on the White Paper. The publications highlighting the consultation included the *Nursing Standard*, *Nursing Times*, *Independent Nurse* and the RCN publication *Bulletin*.
- A **website story** for members featured an article on the NHS White Paper by Dr Peter Carter, Chief Executive and General Secretary of the RCN.
- A **series of Blogs** on the White Paper for the RCN web site including stories by Dr Peter Carter and RCN Head of Policy Howard Catton.
- A **Podcast** was made available for RCN members to provide information on the NHS White Paper proposals. In the podcast Janet Davies, RCN Director of Nursing & Service Delivery and Howard Catton discussed the wide ranging and critically important proposals included in the White Paper.
- An RCN **breakfast round table event** was held on 3rd September with senior representatives of the Royal Colleges and other key health stakeholders.
- An RCN **evening event** was held on 6th September with senior commissioning nurses within Primary Care Trusts (PCTs) in England (including nurse directors). This focused in particular on White Paper issues.
- A **live webcast** with Health Secretary Andrew Lansley and Dr Peter Carter, in which the Health Secretary answered a range of members' questions.

Over **1000 members** contributed to the RCN's response to the White Paper, through the RCN online survey; by responding directly to the issues raised in the factual briefing; or by participating in discussions at branch level, regional board level or at national events organised by the RCN. Overall the consultation process **reached more than 175,000 RCN members**. This does not include publicity achieved through the nursing press and the wider media. In preparing the response to this document the RCN has consulted widely with its members

RCN response to individual chapters of the NHS White Paper

Chapter 1 – Liberating the NHS

Key points

- Nurses deliver care to all NHS service users, from cradle to grave; their impact on patient outcomes and their perspective of the patient experience is unique and vital to any reform of the NHS. How their contribution is to be included in reform must be made explicitly clear by Government.
- The RCN welcomes and shares the Government's commitment to the NHS and its core principles. The RCN is proud of the NHS and the improvements it has made in recent years.
- Whilst areas for improvement still exist in the current system, best practice and areas that are working must be kept and built on in any reform to ensure that previous investment, knowledge and skills are not wasted.
- The RCN warmly welcomes the principles underpinning the NHS White Paper's vision, yet is concerned by the lack of detail about how these principles will be implemented in practice.
- The nursing role is critical in any future reform of public health and social care and the RCN is keen to see further details about these reforms, and how nurses will be able to influence and input into future changes.
- These reforms sit in a context of financial austerity, significant rises in healthcare demand and as found in the RCN's Frontline First campaign, at a time when trusts are making short-sighted cuts in staff to meet £20 billion efficiency savings. The College has significant concerns about the cost of the proposed reform to the NHS and how this will distract attention from delivering high quality care.
- The RCN is extremely concerned by the Government's proposed timescale for implementing the proposals in the White Paper, which threatens the fulfilment of the ambitions it sets out.

RCN comments on individual sections in Chapter 1

Values

Nurses are an integral part of society. Everyone who experiences the NHS will come into contact with a nurse. Nurses play a vital and unique role in delivering and understanding patient care and experiences, from cradle to grave, and in every community in England. The care and treatment they provide directly relates to patient outcomes and the genuine involvement and input of nurses is key to the success of any future development in the NHS, and hence to the ambitions set out in the NHS White Paper.

The RCN welcomes and shares the Government's commitment to the NHS and its core NHS values: healthcare provision based on need and not the ability to pay, providing a fair system which promotes equality.¹⁵ The RCN would urge the Government to unequivocally express its support for a taxation-funded NHS.

The RCN is keen to see more detail on the new role for the Secretary of State and the NHS Commissioning Board in the management and oversight of the NHS. As discussed elsewhere in this document more fully, the RCN believes that national political accountability is an important aspect of the NHS not only as it is a service funded by the taxpayer but also in setting national standards.

The NHS today

The RCN is proud of the NHS. Over the last decade, unprecedented investment and the dedication of NHS staff have resulted in significant improvements in the NHS. Patient satisfaction levels have risen, waiting times have been dramatically reduced and patient outcomes measures have improved. Today the UK ranks highly in international comparison of healthcare systems.¹⁶ Providing 70% of care in the NHS, these achievements have much depended on the hard work, knowledge, skills, compassion and commitment of nurses and the health care support workers within nursing teams. Nurses have notably led the way in infection control and the decline of MRSA and Clostridium Difficile rates. Whilst areas for improvement still exist in the current system, best practice and areas that are working must be kept and built on in any reform to ensure that previous investment, knowledge and skills are not wasted.

Vision for the NHS

The RCN warmly welcomes the principles underpinning the White Paper's vision. Around the White Paper's key principles of patient-centred care and empowering clinicians, **RCN members responding to our White Paper survey overwhelmingly agreed that patients should be at the centre of the NHS (85%) and that NHS staff should have greater freedoms and power to make decisions (79%).**

However, the RCN is concerned by the lack of detail about how these principles will be implemented in practice.

The RCN welcomed the speeches made by Andrew Lansley and Nick Clegg, now respectively Secretary of State for Health and Deputy Prime Minister, at RCN Congress this year where they outlined their intentions to empower nurses.¹⁷ However, in relation to the White Paper's plans to empower clinicians in particular, the RCN is concerned that, throughout the paper and its composites, the Government fails to explicitly mention the role of nursing and nurses, some 70% of the NHS workforce. The RCN needs to see more detail about how the Government intends to involve nursing staff, and all healthcare professionals, in all aspects of NHS reform and healthcare delivery, before it can support this principle. Aspects of the current proposals seem to be based more on a traditional, medical model of provision, rather than the realities of a multi-disciplinary, patient centred and empowered model. Clearly, the failure to fully involve and engage with nurses would be detrimental not only to the NHS and any future reform, but ultimately patient safety and experience also.

15 RCN Principles: a framework for evaluating health and social care policy, October 2008 (See Appendix 1).

16 http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf although there are areas where there could be further improvements http://www.oecd.org/document/38/0,3343,en_2649_33929_44220582_1_1_1_1,00.html

17 http://news.bbc.co.uk/1/hi/uk_politics/election_2010/8647013.stm & <http://www.youtube.com/user/rcnonline#p/u/9/NFIMNzrDeb4>

Improving public health

Nurses play pivotal roles in delivering public health and prevention and the RCN strongly supports the focus on improving public health and tackling health inequalities. Investment in disease prevention will both ensure a better quality of life for future generations and relieve pressure on the NHS.

The RCN welcomes proposals for greater autonomy for local authorities to make decisions based on an assessment of local needs, and the role of local directors of public health in working across traditional practice boundaries to provide an integrated approach. However, whilst the RCN supports locally driven solutions, national oversight of public health outcomes will still be required in order to prevent inequity of access or service quality. The RCN would have concerns if nursing expertise and knowledge about public health delivery and promotion is not fully transferred and utilised in the new structure. Nurses must continue to play a leading role.

The RCN acknowledges that further detail will be set out in the upcoming Public Health White Paper which must provide clarity on a number of the ideas proposed in the current consultation. For example, there is a lack of detail about how public health will be represented in the new commissioning process (and what information and support GP consortia will require) and the size and remit of the proposed ring fenced public health budget.

The RCN notes that plans are already in hand to integrate the work of existing public health and health protection agencies, such as the Food Standards Agency's nutrition function and the Health Protection Agency, into the new Public Health Service. It is important to recognise that the Food Standards Agency has led a number of successful work streams, such as the salt reduction strategy, nutrition signposting and public awareness campaigns. The RCN would not wish to see any of the vigour or independence with which the agency worked 'lost in translation' in a move into the new Public Health Service. Equally, the expertise developed within the Health Protection Agency must be retained and careful consideration given to how new directors of public health will work with the Public Health Service to continue to provide effective long term and emergency planning.

There is no detail on how the ring-fenced public health budget will operate, including on how much scope staff will have to use budgets proactively and innovatively. The RCN is concerned that there is a potential that the proposed separation of the public health budget from the NHS will mean the NHS no longer sees disease prevention and health promotion as its responsibility and will only focus on those that are unwell.

Reforming social care

The RCN has long called for social care reform. The current system is complex and confusing, inadequately funded, unfair, subject to a postcode lottery, and results in high unmet levels of social care needs. Working in both social care and healthcare contexts, nurses have a thorough understanding of and encounter the problems of the social care system and its impact on the NHS. On a daily basis members have to deal with issues like bed-blocking, whilst NHS demand rises in the face of inadequate social care provision.

The RCN has carried out much work with its members on the issue of social care reform, who support a comprehensive system based on fairness, equal access, transparency and simplicity, to allow for the provision of integrated, high quality care.

With rising demand for social care, the current problems are set to worsen. The RCN is keen to contribute to the proposed Commission on the Future of Long Term Care so that the vital and unique perspective and contribution of nurses is not lost in any reform.

The financial position of the NHS

The RCN welcomes the Government's commitment to increase NHS funding in real terms over the coming years. However, the RCN also notes that such increases are unlikely to meet the costs of rising health demand. Tasked with making £20 billion efficiency savings whilst sustaining a 45% loss of management staff, the NHS is clearly entering challenging times.

In addition, the implementation cost of the reform set out in the White Paper has been estimated between £2-3 billion.¹⁸ The RCN does not understand the rationale for making such a costly reform, at a time of financial austerity. Seen together with evidence suggesting that reform will take three years to implement, there is a real risk that the NHS will stand still over this period, with no further improvements to patient care – yet at substantial cost.¹⁹ This is a concern shared by RCN members, who are clearly unconvinced that the White Paper will bring benefits to patient care.

45% of members who responded to the RCN survey disagreed that the White Paper proposals would result in better care for patients. A fifth (20%) of members agreed and a quarter (24%) neither agreed nor disagreed.

The Government therefore has much work to do to convince NHS staff of the merits of the White Paper. The RCN would like the Government to provide more detail and evidence about why it believes this is the right action to take now.

The RCN is monitoring how local trusts are seeking to make efficiency savings, through the Frontline First campaign.²⁰ More than 3,000 nurses have contacted the RCN since the campaign launched in July. Collectively, nurses have to look at ways of saving money but there is real concern that some organisations are using a very blunt instrument to cut costs. The RCN is already aware of more than 10,000 jobs, which have now been earmarked for cuts and are highly concerned that trusts seem to be repeating history in their efforts to save money through reducing frontline staff. There is very little evidence of trusts attempting to meet savings imaginatively or innovatively. This is in the face of evidence showing that appropriate nursing establishment and skill-mix are major factors in enabling quality of care to be delivered.²¹ The RCN will continue to highlight where trusts are taking such short-term approaches to cost savings, at the expense of patient safety and quality care. Frontline First also asks RCN members where trusts might make innovations and real efficiencies and the RCN will share these ideas with Government.

The RCN is concerned that in meeting the Government's 45% target for cutting management costs, management responsibilities will instead be passed to frontline staff. This will reduce the amount of clinical time they can spend with patients/clients and thereby jeopardise patient safety and the provision of quality care. Government needs to ensure that bureaucratic and administrative functions are not simply transferred to matrons, wards sisters and other nursing staff, who already have heavy workloads.

The RCN has concerns about how cuts of 25% to the local government budgets will impact on social care. Further cuts to social care budgets would be at the detriment to social care and NHS users. As explained previously, inadequate funding of social care results in higher unmet social care needs and a greater burden on NHS services as a result. Short term cuts to social care would only lead to higher costs in the future for both the social and health care systems, and would be a short-sighted and costly approach therefore.

18 <http://www.bmj.com/content/341/bmj.c3843.full?sid=270ee017-6dba-4d99-93f7-6963046638fd>

19 http://www.civitas.org.uk/nhs/download/civitas_data_briefing_gpcommissioning.pdf

20 <http://frontlinefirst.rcn.org.uk/>

21 Professor Anne Marie Rafferty of Kings College, University of London, *Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records* (International Journal of Nursing Studies, October 2006)

There are also concerns about the funding of nursing posts for voluntary organisations which have been previously funded by the NHS. Cuts on voluntary sector funding will have a serious knock-on effect for the care and management of long term conditions.

Implementing the NHS vision

The RCN is extremely concerned by the Government's proposed timescale for implementing the White Paper. There is significant risk, identified also by the Chief Executive of the NHS, that during this transition to the proposed reform improvements, current standards of care will be lost and ultimately wasted.²² The RCN strongly recommends that Government takes a piloted and phased approach to these changes to help guard against risk. The RCN is not against change, but is clear that change is best managed and successfully delivered when it is evidence-based and builds incrementally on tried and tested initiatives.

²² Letter from NHS Chief Executive Sir David Nicholson to the chief executive community setting out plans to lead the implementation of Liberating the NHS, 13th July 2010

Chapter 2 – Putting patients and the public first

Key points

- The RCN welcomes the Government's commitment to enabling patients to have more choice over their individual healthcare and to supporting the better involvement of patients and the public in the planning and delivery of health and social care services.
- However, many of the commitments lack detail about their implementation or practical application, and do not reference how they would interact with existing NHS initiatives, for instance care planning.
- There is a distinct lack of consideration of the role that nurses and the nursing profession could play in delivering the outcomes that the Government is seeking to achieve.
- The RCN is gravely concerned that the Government takes little or no account of the proposals' potential impact on disadvantaged or disengaged individuals or communities. This is especially important in relation to the increased use of information to inform patient choice and decision-making, as well as to the more well acknowledged issues relating to involvement and engagement by the health services with disenfranchised communities.

RCN comments on individual sections of Chapter 2:

The RCN recognises and supports the vital role that Patient and Public Involvement and Engagement (PPI/E) has to play in the development and provision of effective and safe healthcare services. The College has recently developed a position on PPI/E which has helped shape our response to this section.

Shared decision-making: nothing about me without me

The RCN supports the principle and practice of shared decision-making, and recognises that good health outcomes are best achieved by a process of cooperation between clinical staff and patients.

In the RCN survey of its members, 85% agree with the principle of putting patients at the centre of the NHS.

Nurses have a significant role to play in delivering shared decision-making, as evidenced by the work undertaken in the development of initiatives such as information prescriptions and care planning.

This applies equally to clinical research, and the RCN has both a long history and a strong presence in the field of patient and public involvement in clinical research, more recently via the RCN Learning and Development Institute.

The RCN welcomes the commitment for the NHS Commissioning Board to champion patient and carer involvement, and for it to be held to account for achieving this objective. However, more detail is needed, and the involvement of nursing and nurses to the interim arrangements, the long-term development and promulgation of shared decision making, and any supporting measures and structural arrangements needs to be ensured.

The RCN would like more detail as to how the NHS Commissioning Board will ‘champion patient and carer involvement’, and how measures to record and assess this support will be created and used. More detail is also needed on the roles that HealthWatch (both ‘England’ and ‘Local’) will play in General Practice Consortia. Lastly, we would like to see more detailed analysis of how care provided for people living with long-term conditions and co-morbidities will be affected by these proposals.

An NHS information revolution

The RCN supports the commitment to increase the availability of information and data to patients about all aspects of healthcare.

73% of the RCN members surveyed agreed with the principle that patients should have more information about the performance of clinicians and service providers in particular.

However, the RCN would wish to caution against ‘information overload’, and would urge the Government to consider its impact; in particular on vulnerable service users. Information that is easily accessible and understandable is far more important than an increase in the volume of information available.

Government must also give careful consideration to the impact of data collection on frontline staff, most importantly in regard to the management of their workload. It must not disproportionately impact on the time that staff have to deliver appropriate care and treatment.

The RCN believes that nurses are integral to enabling patients and their carers to understand, and thus make best use of, data and information; for instance via initiatives such as information prescriptions and care-planning. Additionally, nurses have a specific and important role to play in assisting patients and the general public to interpret and use information to make choices about their healthcare that best fit their individual needs. This is evidenced by the nursing workforce already employed in this capacity by NHS Direct, as well as within general practice and primary care. Further detail on the needs that nurses have in respect of being better able to deliver information will be contained in our response to the NHS Information Strategy Consultation.

In principle, the RCN supports the greater use of Patient Reported Outcome Measures (PROMs), and of patient experience data. Nurses are already a key part of their collection, and of their on-going development; not least because of the amount of time that nurses spend with patients in their roles as care deliverers. We believe that there is also a role for PROMs to be used to incentivise good clinical and caring practice. The RCN expects that all staff involved in meeting good PROMs scores should benefit from such incentives.

The RCN welcomes the support for increased use of clinical audit, and would cite the RCN’s participation in the Health Quality Improvement Partnerships (HQIP) as evidence of our belief in its value. We believe that clinical audit has a wider role than healthcare, and the RCN would welcome the Government’s support for its extension into social care.

The RCN remains committed to its involvement in work around improving accountability within healthcare delivery systems, and specifically for the use, promulgation and further development of Quality Accounts; an initiative to which the RCN has been committed from its inception. However, we note from the National Quality Board report and consultation²³ on the development of Quality Accounts, that a number of

23 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105710

problems have been identified in their use; most notably in the lack of comparability in the data collected. The RCN looks forward to contributing to further Department of Health work on developing their use.

The RCN is supportive of the proposal to make information available at the level of commissioners, and sees this as part of improving the overall accountability of local healthcare systems to the local population that they serve. Further comments on GP Commissioning are contained in the RCN's response to the 'Commissioning for Patients' consultation.

The RCN believes proposals for patient record access and control could be beneficial to patient outcomes, and see nurses as playing an integral part in supporting those patients who wish to hold their own records. This would seem to be a logical and sensible extension of the current approach taken to patient records in maternity care. Further details regarding the support that nurses need to ensure that electronic health records are effectively utilised in healthcare will be contained in our response to the NHS Information Strategy consultation. The RCN has also published a number of reports on this subject.²⁴

In considering the publication of the Information Strategy, the RCN would welcome further detail on how patient record access will impact on nurses' roles and responsibilities, and on what safeguards will be put in place to manage the difficult issues of granting access, for instance to staff other than GPs, and in emergency or limited capacity cases.

The RCN believes that making data available to intermediary organisations, including professional bodies, could play a valuable role in furthering better patient care and improving health outcomes. The RCN welcomes the opportunity, should the Government decide to pursue the proposal, to be involved in the development of an accreditation system and a kitemark. The RCN notes the commitment to providing assistance for individuals who do not access on-line health services, or who would benefit from more intensive support, but feels unable to add further comment in the absence of any detail on how this is to be realised.

Regarding the use of online services, the RCN would like to know how Government envisages them providing services 'much more efficiently'.²⁵ In addition, clarification is required on what safeguards and mechanisms will be in place to ensure service users do not publically misuse systems designed to facilitate open comment and dialogue.

The RCN will provide comment on the Information Strategy and provisions contained in the Health Bill regarding the NHS Information Centre, once they have been published.

Increased choice and control

The RCN believes that there is a role for patients to take more responsibility, where possible. However, we believe that such responsibility can only be developed as a response to the provision of greater public health information, and there is a clear role for the NHS to provide this. Whilst some groups will easily respond to greater information and change their lifestyles accordingly, other groups of patients who, in light of their complex and chaotic lives for instance, will find it extremely difficult to take more responsibility, will continue to need significant support and advice about their health.

Nurses play an integral role in supporting patients in making choices about their healthcare options and in playing an advocacy role for their patients, not least, as previously noted, via initiatives such as information prescriptions and care-planning. In a system with increasing emphasis on the patient choice, appropriate

²⁴ RCN e-health programme, policy briefing on ehealth and nursing practice, June 2009

²⁵ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf - p14

support for staff in advocacy and support roles will be needed (e.g. via programmes such as the Health Foundations' 'Co-creating health'²⁶).

The RCN has concerns that the general public and wider patient community are not fully aware of the White Paper and its proposed reforms, and are thus not fully engaging with the consultation process. Whilst welcoming the Government's intention to engage in more detail on each of the areas outlined, via the proposed discussions with professional and patient groups and in the development of the Health Bill, the RCN would like to see the Government more strongly informing, involving, and engaging the general public about the proposals contained in this white paper, and what it will mean for patients, staff, and the NHS.

The RCN notes the Government's proposal to extend the provision of personal health budget pilots, in line with a review of the evaluation in 2012. The RCN would like to highlight how important it is that Government fully reflects, incorporates and builds on the findings of the evaluation, before rolling out a system that is appropriate for all people, groups and communities. The evaluations of social care individual budgets showed that whilst some groups of service users (i.e. young disabled people) clearly benefited, individual budgets did not work well with other groups (i.e. elderly patients). In view of this, the RCN's position is that personal health budgets must not be obligatory; Government must understand that these budgets are not appropriate for all groups of people. The RCN also has unanswered questions regarding Individual Health Budgets, not least being what happens when an individual spends their budget but still requires care, the implication for a NHS free at the point of need, and what support will be provided for those patients whose use of individual budgets involves them taking on the role of an employer.

The RCN believes that national strategic coordination of the implementation plan is advisable, and that the new NHS Commissioning Board would be well placed to do this role; particularly in view of its future role in monitoring and managing health inequalities. These areas are integrally linked and the RCN will be seeking to engage with the Department of Health on the specific details of its plans.

Patient and public voice

The RCN supports the White Paper's commitment to strengthen the collective voice of patients. Following the Government's involvement and engagement with community groups and organisations, including of patient organisations and of patient and public engagement bodies, the RCN would like to be further consulted about the creation of HealthWatch England, and the transformation of LINKs in local HealthWatch.

In any review of existing mechanisms as they relate to public engagement, including legislation, the RCN would recommend its own set of principles on what constitutes good patient and public engagement, as a guide to this process.

The RCN supports the commitment to strengthening complaints handling structures, and to the strengthening of arrangements for complaints handling, similarly to giving local HealthWatch the power to recommend investigations to take place where poor service delivery is discovered. The RCN would welcome more detail around the proposed changes, and on how they will be implemented in practice.

We have further detailed comments and questions regarding the roles of HealthWatch England and local HealthWatch, which are contained in our response to the 'Local Democratic Legitimacy in Health' consultation.

26 http://www.health.org.uk/current_work/programmes/cocreating_health.html

Chapter 3 – Improving healthcare outcomes

Key points

- Nursing plays a vital and unique contribution to the delivery of health outcomes. Nurses' input into the outcomes framework will ensure it is effective and meaningful, with key insight into the delivery of high quality, safe care.
- The RCN supports a framework that is sufficiently flexible to allow for local responses, whilst providing a robust national NHS framework to allow for comparisons and bench-marking, and to ensure populations across England are not disadvantaged through poor commissioning, poor delivery or inappropriate allocation of resources.
- In terms of public accountability, the RCN agrees that professionals need more freedom to relate to the public they serve but this cannot be at the expense of proper accountability for tax payers' funds.
- It is important to recognise that outcomes are influenced by issues such as staffing and skill mix; internal processes such as team work; safety systems and supervision; and particular patterns of behaviour²⁷.
- Lessons learnt from previous NHS failures at West London Mental Health Trust, Stoke Mandeville Hospital, Mid Staffordshire NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust must be applied in any future reform. Quality of care and patient safety depends on appropriate staffing, an appropriate culture of care, and a climate of openness and transparency.
- The RCN strongly believes there would be value in including measures that are linked to health and wellbeing of the workforce, as these are now shown to have an impact on the quality of services and care to patients.
- Patient experience is also a by-product of staff wellbeing and their experience of the workplace context of care. 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.
- The RCN believes it will be important to discuss how nurses, as a significant part of the workforce, are appropriately rewarded for successful outcomes in care.

The RCN welcomes the Government's commitment to focusing 'on what matters most to patients and professionals' in relation to improving the outcomes of healthcare for all. With regards to professionals, it is important to note the vital and unique contribution that nursing plays to the delivery of health outcomes. There is a wealth of evidence on the role nurses, midwives and health visitors play in improving outcomes by safeguarding patient safety, for instance, through infection control and preventing errors. Nursing input is key to the development of a clinically meaningful outcomes framework, which incorporates insight and understanding of the patient experience and the delivery of high quality, safe care.

27 Plesk, P. E (2001) Redesigning health care with insights from the science of complex adaptive systems. In: Crossing the quality chasm: a new health system for the 21st century, Washington: National Academy Press

Overall, the RCN supports a quality framework focusing on person-centred outcomes. Many of our members agree that scrapping process targets to focus on clinical outcomes, supported by NICE developed quality standards, should be supported.

In the RCN survey of its members 67% said they agreed with the focus on clinical outcomes.

Those outcome measures must be based on evidence-based best practice and should make sense to all the clinicians who will use them. Underpinning such outcomes will be effective IT and real time data capture, which enriches rather hinders the processes of patient care.

The RCN believes that some organisations have focused on targets to the expense of other important priorities. It is important to note that process targets have had a useful effect by describing what is acceptable for patients. It is true that some targets have skewed clinician and managerial behaviour, however, these targets have resonated with the public who have welcomed a reduction in waiting for essential services. Future outcome measures will need to be accessible and understood by the public.

The RCN supports a framework that is sufficiently flexible to allow for local responses. However, it must also provide a robust national NHS framework to allow for comparisons and bench-marking in striving to improve, and to ensure populations across England are not disadvantaged through poor commissioning, poor delivery or inappropriate allocation of resources. An example of areas that could potentially be disadvantaged include offender health and sexual health services. Whilst we support a system allowing for some locally sensitive outcome measures, therefore, we stress the need for some consistency across England to prevent inequity of access or service quality developing for certain population groups or health needs.

In terms of public accountability, the RCN agrees that professionals need more freedom to relate to the public they serve but this cannot be at the expense of proper accountability for tax payers' funds. This necessarily means that politicians are part of the process of planning a response to the nation's health needs. The RCN is pleased to see that the Secretary of State will hold the NHS to account for improving outcomes, but the Secretary of State will be held to account by the public and the professionals of the NHS if the proper frameworks and resources are not in place to deliver the required improvements.

The NHS Outcomes framework

The RCN is committed to continuing to develop a range of indicators for high quality care and is pleased to see that the work done during the Next Stage Review will not be lost.

The RCN notes that there will be separate frameworks for outcomes for public health and social care also. In light of the roles nursing currently plays in these two areas, the RCN expects to be involved in and engaged with in the development of these frameworks, in addition to the NHS Outcomes Framework.

The role and, hence insight and understanding, that nursing has around the three domains of quality suggested for the NHS Outcomes Framework, makes the case clear to see for the need to consult with nurses in its development.²⁸

There is a wealth of solid evidence regarding the registered nurse (RN) contribution to preventing deterioration in patient health through rapid intervention, reducing infection, building a climate of safety,

28 1) The effectiveness of the treatment and care provided to patients, 2) the safety of the treatment and care provided to patients, and 3) the broader experience patients have of their treatment and care they receive.

reducing costs and preventing errors in the management of medicines. The impact of adequate RN staffing is clearly understood and should be an integral part of the framework²⁹.

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;³⁰ 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.³¹ 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 Trust³², Mid Staffordshire NHS Foundation Trust³³, Stoke Mandeville Hospital,³⁴ and West London Mental Health NHS Trust³⁵. 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.³⁶

In view of the above, the RCN strongly believes there would be value in including measures that are linked to 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 Boorman Report found clear links between staff health and wellbeing and the three dimensions of service quality: patient safety; patient experience; and the effectiveness of patient care.

A failure to learn from the above evidence will devalue the impact of these reforms and risk patient, public and staff wellbeing.

There is still a major debate about the role and development of meaningful PROMS. The issue of how the data is gathered in a sensible and sustainable manner is dependent on IT systems designed to compliment care processes, not inhibit them. Further, regular use and interpretation of PROMs in practice will require investment in staff and infrastructure to enable its meaningful use.

Patient experience should be a core aspect of outcome measurement. The Equality and Human Rights Commission (EHRC) in their Equality Measurement Framework has developed a measurement of equality based on 'outcome' 'process' and 'autonomy' across 10 domains – one of which is health³⁷. The RCN would

29 RCN Policy Unit, *Setting appropriate ward nursing staffing levels in NHS Acute Trusts*, September 2006

30 Boorman et al (2009) *NHS Health and Wellbeing: Final Report*

31 Plesk, P. E (2001) *Redesigning health care with insights from the science of complex adaptive systems. In: Crossing the quality chasm: a new health system for the 21st century*, Washington: National Academy Press

32 Healthcare Commission (2007) *Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust*

33 Francis, R. (2010) *The Mid Staffordshire NHS Foundation Trust Inquiry*. Available online at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113447.pdf. Accessed 13 August 2010

34 http://www.cqc.org.uk/_db/_documents/Stoke_Mandeville.pdf

35 http://www.cqc.org.uk/_db/_documents/Investigation_into_West_London_Mental_Health_NHS_Trust_FINAL_200907171608.pdf

36 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018

and

<http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/151/151i.pdf>

37 http://www.equalityhumanrights.com/uploaded_files/emf/chapter_5_health.pdf

endorse the measurement of ‘autonomy’ closely linked to choice and control in relation to treatment, information and consent and that ‘process’ is linked to experience of dignity and respect as recipients of care. It is known that particular individuals and groups experience discrimination or other forms of unequal treatment within services.

It would be important to learn lessons from previous real time data gathering exercises where effective IT was used to gather patient experience during the care episode. Surveys are useful but their scope is limited and without standardisation of questions or method, there is a risk of manipulation and loss of credibility.

Patient experience is also closely correlated with staff wellbeing and their experience of the workplace context of care³⁸. Patient experience measures need to be cross referenced with staff experience measures (such as staff surveys) to highlight where organisations are failing to invest properly in an appropriately skilled and sustainable workforce.

The RCN believes that Government must be mindful of creating a patient experience industry that is diffuse, unrelated to actual patient need, or so variable across the country as to make comparisons meaningless. It remains important to focus on fixed measurables, not variables such as satisfaction.

The culture and context of care is incredibly important. The RCN is already aware of the role this can play in staff confidence and the ability to report poor care and deal meaningfully with patient concerns when raised.

Developing and implementing quality standards

Research

The RCN welcomes the Government’s commitment to the promotion and conduct of research as a core NHS role, and its acknowledgement that research plays a vital role in providing knowledge to improve health outcomes and reduce inequalities.

Incentives for quality improvement

Changes in outcomes in this area need to be cross referenced with levels of provision and investment in community services and social care. The RCN would urge that careful consideration is given to the financial incentives, and penalties, that accompany measures incentivising activity. In particular, there is a danger that the use of penalties may fail to uncover and address the causes of failure and may be used, where instead support may be needed.

There is anecdotal evidence from RCN members that shows how poorly constructed incentives can exacerbate access of services downstream for some patients where services are unconnected, or where they distort care pathways around pinch points; areas sensitive to payment or measurement.

The RCN believes it will be important to discuss how nurses, as a significant part of the workforce, are appropriately rewarded for successful outcomes in care. There is already substantial evidence that high quality nursing care reduces mortality, morbidity, and incidence of infection. If providers are to be financially rewarded for improvements in outcomes, it will be important to review how those financial gains are shared with clinical teams, invested into service improvements and staff development.

³⁸ *Good practice in infection prevention and control, Guidance for nursing staff*, RCN, Nursing Standard, Kimberly Clark, Infection Control Nurses Association, April 2005

Chapter 4 – Autonomy, accountability and democratic legitimacy

Key points

- Nursing must be formally represented at a senior level in commissioning consortia and on the NHS Commissioning Board. Nursing expertise must also be recognised and utilised at all levels of the commissioning process. The RCN calls for nurses to be included within all General Practice Consortia and NHS Independent Board structures by holding senior positions on their governing bodies.
- Modern general practice is delivered by a multi-disciplinary healthcare team. The RCN believes that 'clinical commissioning' and 'clinical commissioning consortia' are more appropriate terms than 'General Practice commissioning consortia' and would be more reflective of the role played by all healthcare professionals.
- The RCN calls for more detail on the proposed structure and role for the NHS Commissioning Board including what the term 'independence' will mean in practice.
- The NHS is a vital public service and costs the taxpayer substantial sums of money. Given the retention of significant strategic decision making by the Secretary of State for Health accountability must not be side stepped; nor must the value of political scrutiny to ask questions on behalf of the public and patients be ignored.
- In view of the evidenced link between staff engagement and their employment conditions and patient outcomes the RCN can only support social enterprises where there is a robust and sustainable individual case for change that will benefit patients and where NHS pay terms and conditions are available to all staff.
- The RCN cannot support the removal of the private income cap. Until foundation trusts can credibly demonstrate that private income is not at the expense of NHS patients, the current arrangements for the cap should remain in place. The RCN does not believe that there has been sufficient analysis to justify the proposed changes in this area.
- The RCN fully supports the critical functions performed by the CQC in terms of ensuring the quality and safety of care provided in the NHS. The RCN believes that the CQC should be fully supported to mature and develop as an organisation.
- The RCN supports the principle of intelligent regulation for health and social care systems. Questions remain about the ability of Monitor to expand its functions to cover economic regulation, and how it will manage the conflict of interest implied by its role to both protect services as well as promote competition.
- The RCN calls for regulators to be provided with appropriate resourcing and for more unannounced inspections and staffing metrics to be explicitly included within regulatory approaches. This is even more important if there are to be more providers involved in delivering NHS services under the any willing provider arrangement.
- The RCN believes that the CQC and Monitor should include standards and targets on staff health and wellbeing in assessment processes and standards for best employer practice including staffing levels and staff engagement.

- The RCN continues to support the introduction of foundation trusts on a case by case basis. There are considerable risks in moving all remaining acute trusts to Foundation Trust status within 18 months, which could result in a lower level of quality.
- The RCN believes that there needs to be clarity between the relative benefits of both the social enterprise and foundation trust models.
- The RCN supports close health professional involvement in decisions about education and training, and looks forward to seeing more details on the Government's proposals.
- The RCN believes that any move away from national pay as proposed in the NHS White Paper would be an expensive folly, distract NHS employers from their core purpose of delivering quality patient services and would have a disruptive effect on the nursing labour market severely affecting the recruitment and retention of nurses.
- The RCN believes that nurses' pension arrangements must be protected when they are moved from the NHS to a non NHS provider and that staff delivering NHS funded services should have the same entitlement to NHS scheme benefits as those who remain in the NHS. The RCN considers the portability of the NHS Pension Scheme as an important priority and the stability of the NHS Pension Scheme would potentially be put in jeopardy if appropriate transfer arrangements were not assured.

RCN comments on individual sections in Chapter 4

GP commissioning consortia

Nursing must be formally represented at a senior level in commissioning consortia and on the NHS Commissioning Board. Nursing expertise must also be recognised and utilised at all levels of the commissioning process. The shift from a target-driven to an outcomes-driven NHS cannot happen without the involvement of nurses in commissioning. Nurses have an invaluable insight into the practical issues of service delivery, including advice on value for money, efficiency, and effective and quality care provision. **They have a pivotal role in being able to stand back and view the whole care pathway, take a holistic perspective to look above the day to day clinical issues and effectively support commissioners in the decision making process.** Some solutions to commissioning will inevitably be nurse-led; modern healthcare services are increasingly nurse-led as a response to changing healthcare needs. These include specialist services, such as cancer services, and many public health initiatives. The profession must therefore be involved at every stage and level of the design, commissioning and implementation of services.

In the RCN survey 86% of those members who responded felt that nurses should have a central role in the commissioning of patient services in the future.

The White Paper states that General Practice Consortia commissioning will “reinforce the crucial role that GPs already play in committing NHS resources through their daily clinical decisions.” The RCN is concerned by the explicit failure to acknowledge that nurses also play this role on a daily basis. Nurses' expertise must be fully harnessed to make commissioning successful.

Modern general practice is delivered by a multi-disciplinary healthcare team. The RCN does not believe

that the term 'General Practice commissioning consortia' adequately reflects this reality and the role played by all healthcare professionals. The term is likely to be confused with general practitioners, rather than general practice as a whole. For this reason, the RCN believes that 'clinical commissioning' and 'clinical commissioning consortia' are more appropriate terms.

The RCN does not support the restructuring of commissioning for restructuring's sake and is concerned that the structures proposed are not based on clear evidence. This caution is shared by RCN members.

71% of members who responded to the RCN survey did not agree that the responsibility for the bulk of the NHS budget should be handed to general practices to commission/buy services.

Further evidence as to why the White Paper's proposed structures would more effectively commission NHS healthcare services is needed. There is a danger that in time the existing structures and functions of commissioning will be replicated, in all but name. Delivering on these proposals will require substantial investment, both financial and by staff and could impact on the current levels of care provided.

In any reform, the lessons from previous experiences of changing commissioning systems (including GP fund holding and Practice Based Commissioning) must be learnt. Evidence continues to emerge of the success of some PCTs in demonstrating progress and improvement in world class commissioning scores³⁹ and in delivering on local health priorities⁴⁰. Commissioning functions that are being carried out well should not be wasted, but instead developed and built on. There is a real danger that this reform could lead to a drain in skills as staff leave the NHS and the existing nursing expertise and leadership within these structures is lost.

GP practices will lack commissioning experience, and it will take time to develop the necessary infrastructure and skills⁴¹. As the independent NHS Commissioning Board is to be charged with setting the strategic direction for commissioning, they should ensure that commissioners build on care pathways and move towards integrated working. The RCN also strongly believes that the Board should ensure a core focus on addressing health inequalities, which was a particular concern raised by our members when commenting on the White Paper proposals.

If Government continues with the current plans for restructuring, the RCN strongly urges ministers to adopt a phased approach to implementation. This means evaluation, adaption, sharing best practice and building on what is already known about good commissioning.

An autonomous NHS Commissioning Board

The RCN calls for more detail on the proposed structure and role for the NHS Commissioning Board, and, if established, its regional offices.

When asked about the creation of the Board, RCN members were clearly undecided. This may reflect the lack of detail contained within the proposals covering this area.

In the RCN survey 37% of members agreed and 30% of members disagreed with the formation of an

39 <http://www.hsj.co.uk/Journals/2/Files/2010/8/11/World%20class%20commissioning%20league%20tbl1.pdf>

40 *Commissioning in the new world: an analysis of the impact of prioritisation on quality, expenditure and outcomes in the health service* (2010) Health Mandate

41 *Nuffield Trust Briefing The Coalition Government's NHS Reforms, an assessment of the White Paper*, August 2010

Independent NHS Commissioning Board.

The RCN believes that it is imperative that there remains a clear line of political accountability between the general public and national politicians for NHS-funded services.

The NHS consumes significant public resources and, therefore, will inevitably always be a political issue both at national and local level (for example, by local MPs campaigning to keep open their local hospital). Politicians should scrutinise the NHS and decisions made by the Secretary of State for Health on behalf of the public and patients. The RCN does not see removal of the political involvement in the way described by the NHS White Paper as credible, realistic or desirable. There must be clear accountability for public funds

The RCN notes the statement that the Board will “manage an overall NHS commissioner revenue limit” that is presumed to mean that the Board will be responsible for staying within budget.⁴² We also note that there are separate influences on managing the budget which will fall outside of the Board’s remit; namely setting tariffs and decisions on the services the NHS will provide. This suggests a fragmented approach to managing financial constraints and will require close working across the system as a whole.

Local democratic legitimacy

The RCN supports involving patients, individually and collectively, across health needs assessment, planning, commissioning, provision and monitoring of health and social care services. Both the NHS and the social care system are there to deliver services to some of the most vulnerable people in our society and they are essentially the ‘customers’ of those services. Nursing staff spend considerable amounts of time with patients and their carers and, where necessary, advocate on their behalf. Suitable representation of nurses in these structures that support involvement is vital.

Whilst the RCN supports the Government’s intentions in this area there are concerns that the proposals, even in the more detailed related consultation, appear to be vague. There are two specific questions:

- For LINKs becoming local HealthWatch, what will be the arrangements regarding the current ‘Hosts’, and how is it envisaged that local authorities will commission services from local HealthWatches?
- What does the Government propose for the future of Patient Advocacy and Liaison Services (PALS), and for their relationship with local HealthWatches, and HealthWatch England?

The RCN calls for the Government to set out in more detail the relationship between the two HealthWatches, especially on how local HealthWatches can trigger action by HealthWatch England.

Freeing existing NHS providers

The RCN notes that the NHS White Paper is likely to increase the level of competition in the NHS, and increase the number and range of different providers in delivering health care. The independent sector, which encompasses a wide range of providers from not for profit organisations right across to commercial organisations, has always had some part in providing NHS services. The RCN accepts that there is a role for the independent sector including the voluntary sector, the commercial sector, and social enterprise in delivering NHS funded services.

42 (paragraph 4.11) NHS White Paper: Equity and Excellence: Liberating the NHS

Although we have taken this approach to the independent sector, the RCN and its members who work across both the NHS and the independent sector remain strongly committed to the NHS and the underlying principles of a publicly funded service which is free at the point of delivery and based upon clinical need, and not on ability to pay. The RCN recognises the cooperation between the NHS and the independent sector, but would not want to see unnecessary fragmentation of NHS services which would threaten the delivery of safe, high quality care and create barriers for staff in moving across service areas and employer organisations.

In the RCN survey of its members 63% disagreed and only 20% agreed with the private sector and the independent sector being given a greater role in providing health care services.

The RCN supports the development of early warning systems⁴³, development of the broader ‘failure’ regime⁴⁴, and evolving principles for co operation and competition⁴⁵, assurance processes for assessing changes in service delivery under specific programmes such as Transforming Community Services⁴⁶, and an ‘intelligent’ regulatory approach⁴⁷. These should apply to all providers. However, the College still has questions about how many of these policies and organisations will work in practice as many remain as yet untested.

Whilst the RCN welcomes the statement that “the Government’s reforms will liberate professionals and providers from top-down control”, there still needs to be strong and robust accountabilities in place. The same principle applies to all providers of NHS funded services. Commercial providers should not be able to use commercial sensitivities as a way of avoiding political and public accountability and scrutiny.

It is important to learn the lessons from previous Government policies to ‘open up the health market’ to the independent sector, for example the Government was unable convince the Parliamentary Health Select Committee in 2006 that the benefits gained from contracting out operations to Independent Sector Treatment Centres (ISTCs) were greater than if they had been delivered within the NHS⁴⁸. Lessons can also be learnt from other countries, for example the experiences of the health-care sector in Sweden who introduced a market model which resulted in reduced access to patients and greater inequalities⁴⁹.

The RCN opposes the removal of the private income cap. Until foundation trusts can credibly demonstrate that robust checks and balances are in place and private income is not at the expense of NHS patients the current arrangements for the cap should remain in place. The RCN does not believe that there has been sufficient analysis to justify the proposed changes in this area. There is a risk that private patients could be the focus of work at the expense of NHS patients and that an already over-stretched staff resource will be stretched even further.

43 RCN briefing, Review of Early Warning Systems in the NHS, 2010

44 RCN response to consultation on a regime for unsustainable NHS providers, December 2008

45 RCN response to consultation on Cooperation and Competition Panel Guidance Documents, April 2009

Also see RCN, Competition in the NHS in England, 2010 Available from:

http://www.rcn.org.uk/__data/assets/pdf_file/0020/314615/07.10_Compensation_in_the_NHS_in_England.pdf

46 See Joint Trade Union Guide on TCS Available from: http://www.rcn.org.uk/__data/assets/pdf_file/0003/310998/TCS-jointunionadvice_and_guidance.pdf and supplement Available from:

http://www.rcn.org.uk/__data/assets/pdf_file/0004/310999/TCS-tradeunionguide-sup0410.pdf

47 RCN Policy Unit Briefing 05/2009 Looking Back to Look Forward: Key lessons from system regulation of health and social care in England. Please see the RCN’s response to CQC consultations at www.rcn.org.uk

48 <http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/934i.pdf>

49 Market reforms in health care and sustainability of the welfare state: lessons from Sweden Volume 32, Issue 1, Pages 141-153 (April 1995)

In the RCN survey of its members 31% agreed and 45% disagreed with the proposal that every NHS Trust should become a foundation trust with extended freedom and autonomy.

The RCN supports changes that bring benefits for patients⁵⁰, but stresses that mergers and de-mergers can have significant impacts upon both patients and staff. So proposals for change must be developed in partnership with all stakeholders, be rigorously tested, and if taken forward, change is proactively managed to mitigate staffing and patient risks and ensure the proposed benefits materialise in practice.

The RCN calls for the Government to rapidly set out in more detail for the role and approach of Monitor as an economic regulator. In essence, a new set of rules have been proposed and there needs to be clarity about how these will work in practice, and how they will be able to minimise potential downsides of the proposed changes.

Following a survey of members, the RCN expressed concerns about the current working of foundation trusts: not all foundation trusts are providing the degree of transparency and involvement required. This should be urgently remedied before greater freedoms are granted.

There is a need to continue to manage the risks of failure of foundation trusts. This is emphasised if the Government continues with the planned transfer of all acute NHS Trusts to full foundation trust status. The RCN believes that foundation trusts should be considered on a case-by-case basis. However, the current proposals appear to set out a blanket policy of forcing changes on providers that may be neither wanted nor appropriate. NHS trusts should only seek to become foundation trusts, with all the freedoms they encompass, if they meet the needs of all local stakeholders. The White Paper's proposals to complete this process within 18 months also appears to be overly ambitious. The RCN is concerned that the bar set by the regulator will, in reality, be lowered in order to achieve this timetable.

The White Paper suggests a range of models for trusts including a social enterprise version of foundation trusts. The RCN views this approach as simplistic and potentially confusing. Until more information is provided by the Government, including the regulatory approach as crucial checks and balances in the system, it is not possible to determine whether this represents an opportunity or a threat to patients and staff. The RCN wishes to emphasise that whatever models are agreed and taken forward (both in the acute and community settings) commissioners must be consistently proactive in order to bring out the best from all providers. The system as a whole needs to be made to work including clear accountabilities as well as robust checks and balances.

Economic regulation and quality inspection to enable provider freedom

The RCN sees a crucial role for regulators in the NHS as part of the system of checks and balances. The proposed changes that will give greater freedoms, and potentially more involvement from a plurality of providers, necessitate a very clear set of standards and credible checks and balances in the system. Regulators need to respond to a more diverse range of providers and plan for the longer term. If the number and type of providers increases, it is important to ensure that they operate in ways that deliver high quality, safe care. The CQC (and others) have a role to play in setting standards and monitoring providers⁵¹. In particular, the CQC has a number of enforcement powers ranging from fines through to closing a provider down. The CQC therefore can bring to bear strong incentives for providers to ensure that they

⁵⁰ RCN publication (2008) RCN principles to inform decision making: what do I need to know? Available at http://www.rcn.org.uk/__data/assets/pdf_file/0009/78696/003034.pdf

⁵¹ *The Regulatory Landscape in Health and Social Care in England in 2009*, RCN Policy Briefing, June 2009

deliver high quality safe care. It is essential that the CQC has effective powers and the resources required to mark it out as a robust and effective regulator.

Overall, more detail is required to reassure the RCN and its members that the necessary checks and balances will be in place. For example, there are limited details set out on the tests that Monitor would use in order to detect: anti-competitive behaviour via regular data collection and analysis; how breaches of the licence could be detected via other routes; in what amounts to a crucial new set of ‘rules of the game’ for providers. There is also a tension between the new remit to both protect services and promote competition.

As part of its new proposed remit Monitor will have an opportunity to reconsider the payment by results tariff, and avoid setting the tariff at levels which are insufficient to cover safe nursing staffing levels. The RCN has provided further commentary on the payment by results system within its response to Chapter 5 of the White Paper.

The RCN also highlights that in the case of financial failure there is a responsibility for Commissioners to ensure continuation of services. Staff will be most critical in continuing to deliver services during a period of administration and so there will need to be strong and effective partnerships with staff and trade unions during this time.

The RCN fully supports the critical functions performed by the CQC in terms of ensuring the quality and safety of care provided in the NHS. The RCN believes that the CQC should be fully supported to mature and develop as an organisation. The RCN has consistently called for ‘intelligent’ regulation with sufficient levels of monitoring, investigation, and inspections, appropriate metrics and timely intervention by the regulator where quality of care is found to be poor. The RCN asks that there are sufficient resources allocated to all regulators to fulfil their remits and that staffing metrics are also included within their assessment criteria.

Valuing staff

There is increasing evidence to support the Government’s view that that staff morale and wellbeing is linked to better patient care. The Boorman report⁵² found clear links between staff health and wellbeing and the three dimensions of service quality: patient safety; patient experience; and the effectiveness of patient care. In particular it was noted that there was a strong relationship between staff health and wellbeing and key issues such as MRSA rates. These findings within the report were confirmed by a staff survey, which found that 80% of staff felt that their health and wellbeing impacts on patient care.

It is clear therefore that staff health and wellbeing should be incorporated with other NHS priorities, especially those linked to patient outcomes. The RCN welcomed the Government’s commitment to the Boorman Report by pledging to implement its recommendations through the NHS Operating Framework. Research published by Aston University examined and evidenced the link between staff and patient satisfaction, the link between people management and organisational performance in the NHS, staff involvement and organisational performance in the NHS.⁵³

The RCN has further argued in its response to the White Paper consultation on Transparency and Outcomes that staff health and wellbeing should be included in the Transparency in Outcomes Framework. The RCN also believes that the CQC and Monitor should include standards and targets on staff health and wellbeing in assessment processes and key to this is to also include staffing metrics to ensure that staffing levels are safe – for both patients and staff.

52 Final Report of the independent NHS Health & Wellbeing, the Boorman Review, published on 23 November 2009.

53 <http://www1.aston.ac.uk/aston-business-school/research/structure/centres/ihse/research-projects/#NHSHealthandWellbeing>

The RCN believes that individual employer organisations should be required to:

- develop a local health and wellbeing strategy with full involvement of staff and their representatives
- focus on preventing work related causes of ill health, and avoid work-related stress by ensuring there are sufficient nursing staff to meet service needs safely
- focus on behaviours of management to ensure that they do not contribute or undermine staff health and wellbeing and ensure that management have the skills to support staff with mental health problems.

Additionally, the RCN has undertaken employment surveys of its members over a 24 year period. The surveys have found consistently that feeling valued and engaged is an important factor in morale and motivation. As well as developing standards and targets relating directly to health and wellbeing therefore, the RCN would like to see more general requirements for best practice in respect of employer practices and procedures including staff engagement.

Training and education

The RCN accepts that there is a legitimate role for employers in workforce education and training. However, we believe it is essential that there is national oversight of nursing education and the commissioning of nursing education to protect national standards and ensure that the future workforce is fit for purpose. An NHS Commissioning Board to provide oversight of the funding plans for training is to be welcomed working in tandem with the new proposed Centre for Workforce Intelligence. However, the RCN has concerns about GP consortia overseeing training at a local level. There is a lack of detail behind the vision for this area set out in the White Paper and the College would welcome the opportunity to receive more information on the Government's proposals.

The RCN is concerned that the sections of the White Paper covering new arrangements for education lack detail and appear to disregard the role and importance of nursing leadership, in favour of a traditional, medical model of healthcare provision. Historically, nursing leaders have had a key role in commissioning education. Nursing and the allied health profession not only understand the skills and attributes of the wider health and social care team, but also their development and training needs. The Prime Minister's Commission on the future of Nursing and Midwifery in England recommended that urgent steps be taken to strengthen nursing education and research; develop and sustain the educational workforce; facilitate sustainable clinical academic career pathways; and further develop nurses' and midwives' research skills⁵⁴. Behind these recommendations lay a clear assertion that nurses must be able to lead and apply their expertise in this area. The RCN looks forward to receiving more detail on the Government's plans later in the year and calls for inclusion of the recommendations of the Prime Minister's Commission on Nursing and Midwifery in this vision.

Nurse leaders are uniquely placed to play a role in the commissioning of education. Their comprehensive knowledge of educational commissioning systems and understanding of multi-disciplinary care pathways will be essential for future decision-making. There has been an increasing blurring of boundaries across care pathways with teams of staff combining medical and non medical staff. Nurses have shown themselves able to work within these new ways of working and help form a bridge between health and social care systems.

54 Front Line Care: the future of nursing and midwifery in England. Report of the Prime Minister's Commission on the Future of Nursing and Midwifery in England 2010.

The RCN welcomes the commitment of the Government to involve all health and social care providers in the commissioning process. Since the third sector will increasingly need to expand their healthcare workforce it is appropriate that they should be involved in workforce planning at all levels. However, there is currently no clear mechanism outlined detailing how this involvement will be achieved in practice.

Medical Education England (MEE) has worked effectively because healthcare professionals have been closely involved. Commissioning of nursing and Allied Health Professionals (AHP) training is considerably more complex and involves many more providers. The RCN calls for the Government to urgently consider whether there should be a new separate body for nursing and AHP commissioning. The College welcomes the proposal for a Centre for Workforce Intelligence to provide current information and reliable analysis on which to base workforce and training and commissioning decisions but has real concerns that the current stakeholders involved in the work of Centre for Workforce Intelligence appear to be focused on medical practitioners. The RCN developed a very strong and effective relationship with the Workforce Review Team, yet it is concerned that the new organisation proposed may not maintain the same level of investment in the future of the nursing workforce.

The RCN believes there is a need for a comprehensive workforce planning system and strategy, which covers all providers delivering NHS funded services. The RCN recommends that employer organisations should be including non-mandatory training in their training and workforce plans and that training become a protected element in financial plans. Without adequate investment in all parts of the nursing workforce, healthcare organisations will continue to struggle with staff shortages, poor skill mix, bed pressures, preventable morbidity and mortality, and poor provision of community health services.

NHS pay

The RCN strongly believes that any move away from national pay as proposed in the White Paper would be an expensive folly, distract NHS employers from their core purpose and would have a disruptive effect on the nursing labour market, severely affecting the recruitment and retention of nurses.

In the RCN survey of its members 92% agreed that the Government should protect national pay and conditions rather than enabling local deals.

The RCN believes that a national pay system provides both the service and staff with stability and security particularly during periods of transition and fiscal challenge and that a move to local pay determination would put this at risk. The current national multi year pay deal 2008 – 2011 is providing financial stability and control during a period of economic and financial uncertainty. The Government itself has exploited the opportunity for control and stability of pay inflation offered by a national pay system by implementing a two year pay freeze.

Furthermore, a national pay system provides important economies of scale; locally determined pay would require resources to undertake negotiations which would reduce resources available for services and necessarily distract Trusts from their core purpose. An experiment with local pay determination in the NHS in the 1990s was unpopular with employers and ultimately abandoned for this reason. A later experiment with geographical cost of living supplements in 1995 at a time of continuing nurse shortages, exposed the potential for neighbouring trusts to increase financial inducements in competition for scarce nursing resource destabilising workforces at the expense of quality nursing care.

It is not the case as argued in the NHS White Paper that Governments impose pay decisions and that only foundation trusts have the right to determine pay for their own staff. In fact, while ministers have overall

control through the formal sign-off of agreements and pay reviews, the current system allows employers to influence the pay, terms and conditions package through the NHS Staff Council and in providing their own evidence to the Independent Pay Review Body. The current Agenda for Change (AfC) package provides flexibility to meet the needs of employers through recruitment and retention premia and high cost of living payments. However, employers have, in the main, chosen not to exploit these flexibilities, largely because it would be time consuming and expensive.

It is important to remember that some key drivers for introducing the AfC national pay and career progression framework remain, namely: equal pay for work of equal value, recruitment and retention of staff and improving local flexibility. As well as providing employers with flexibility through recruitment and retention premia and high cost of living allowances to meet local labour market demands, AfC assists changing ways of working and removing barriers to change through a national job evaluation scheme and Knowledge and Skills (KSF) competence framework. These cover all staff groups and allow employers to create a greater diversity in job roles and reinforce cross-professional team working.

The RCN strongly argues that a drive for local pay will not only prove to be expensive in terms of transactional costs but that it could potentially re-introduce the risk of equal pay claims. Such a move would also increase the possibility of industrial unrest and most importantly, take financial and management resources away from a focus on improving frontline clinical services. Overall, RCN members strongly support a national pay terms and conditions framework underpinned by an independent Pay Review Body. RCN members also support the Cabinet Office code and the NHS standard contract model, which require employers to deliver pay equity and access to a fair pension for all staff delivering NHS services. Removing the current national pay frameworks will create a barrier to change and staff flexibility.

NHS pensions

As the health care market has shifted to a more pluralist system, the importance to nurses of being able to retain their pension arrangements when transferring out of the NHS has been highlighted. Being able to retain membership of the NHS Pension Scheme assists retaining the skill and expertise of experienced nurses. Some commentators however have focused on how the requirement under 'Fair Deal' for broadly comparable schemes to be offered might limit providers from entering the market⁵⁵. On the contrary, independent and private sector providers have acknowledged the benefit of being able to offer NHS Scheme membership precisely because this assists in retaining vital skills necessary to deliver good quality care.

In the RCN survey of its members, 67% agreed that the NHS White Paper would make it difficult for those with existing NHS pensions to keep their current pension benefits.

The RCN strongly believes that nurses' pension arrangements should be protected when they are moved from the NHS to a non NHS provider and that staff delivering NHS funded services should have the same entitlement to NHS scheme benefits as those who remain in the NHS as directly employed staff. Given that the White Paper signals further pluralism, the RCN believes that the portability of the NHS Pension Scheme is essential and, furthermore, that the stability of the NHS Pension Scheme would potentially be put in jeopardy if appropriate arrangements are not made.

Chapter 5 – Cutting bureaucracy and improving efficiency

Key points

- The RCN welcomes the plans to remove unnecessary bureaucracy that impedes the ability of nurses to deliver patient care. However, the RCN has concerns over how proposals to make the ‘largest reduction’ in administrative costs will impact on the quality of care at a time when the NHS is already having to find ways to save £20 billion.
- Any reform of current NHS structures must be considered with a view to minimising waste of current expertise and with a view to total systems management approach to ensure the sustainability of healthcare services.
- The key to delivering real and beneficial NHS productivity is to work in close partnership with NHS staff and their trade unions.
- The NHS cannot afford to lose the skills, knowledge and experience that senior nurses working with SHAs and PCTs have developed. Any such loss would directly be felt across patient care.
- The Government needs to be careful that by reducing administrative posts front line nurses are not given more administrative duties, taking their time away from direct patient care.
- Many of the arms-length organisations facing significant change have been instrumental in protecting and promoting good health. The Government must ensure that the key functions they perform, particularly with regards to improving quality, are not lost in a re-organised system.

RCN comments on individual section of Chapter 5

Cutting bureaucracy and administrative costs

The RCN welcomes the Government’s plans to remove unnecessary bureaucracy that impedes on the ability of nurses to deliver patient care. However, the RCN has concerns over how proposals to make the ‘largest reduction’ in administrative costs, at a time when the NHS is already having to find ways to save £20 billion, will impact on the quality of care. There must be honest conversations about the impact such savings and reform will have on the quality of services and care.

The RCN believes that much greater consideration needs to be given over plans to reform and abolish current commissioning structures (PCTs and SHAs). Any reform of current NHS structures must be considered with a view to minimising waste of current expertise and with a view to total systems management approach to ensure the sustainability of healthcare services.

In the RCN survey, 55% of those members who responded disagreed with the Government’s proposals to abolish PCTs and SHAs, whilst 26% of respondents agreed.

The Government needs to be mindful that an unintended consequence of reducing administration costs is frontline staff carrying out more administrative duties, therefore taking their time away from direct patient

care. The same applies for the proposed cuts in management of up to 45%⁵⁶. In addition, staff need appropriate management support to carry out their roles, particularly during a period of change, and the Government must fully consider and manage the impact of this cut on patient care and on implementing the White Paper's reforms.

Nursing leadership

One of the 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. Yet the White Paper's proposals risk damaging the success achieved in recent years in building nursing leadership capacity. If nurses are to rise to the challenge set out in the White Paper, nursing leadership must be protected and enhanced within the restructure of the Department of Health and NHS funded organisations. The NHS cannot afford to lose the skills, knowledge and experience that senior nurses working with SHAs and PCTs have developed. Any such loss would directly be felt across patient care. Ward sisters and the equivalent leaders within community settings are the lynchpin for nursing staff, whose leadership can help implement reform and drive an outcomes based approach.

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.⁵⁷

Nurses are the largest professional group involved in care delivery and are in the unique position of caring for patients throughout whole pathways of care. They are well versed at putting patients at the centre of care and acting as their advocates. Andrew Lansley, now Secretary of Health, highlighted to RCN Congress earlier this year that "nurses are now taking on new responsibilities and new opportunities for leadership" and stated that "I think this is definitely how we want to go in the future". Yet nurses and nursing is notable in its absence in the vision set out in the NHS White Paper. There is a risk that nurses' professional leadership could be seriously diluted as a result of the demise of strategic health authorities, primary care trusts, and of a smaller Department of Health. The RCN calls for more detail from the Government about how it intends to continue to support nurses to provide leadership, and increase NHS productivity and quality. The term "Clinical Leadership" needs to embrace nursing in the same way it embraces medicine.

Increasing NHS productivity and quality

Nursing has a leading role in innovation and a track record of success in continually developing quality. This was recognised by Lord Darzi during the NHS Next Stage Review⁵⁸. Nurses can be motivated and are willing to innovate. 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 and acute pain services.

56 The Coalition Government's NHS Reforms: an assessment of the White Paper, the Nuffield Trust, 10th August 2011

57 *Breaking Down Barriers; Driving up standards: The role of the Ward Sister and Charge Nurse*. The Royal College of Nursing 2009

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

The RCN believes that nurses can be the champions of change, raise standards and embed innovation and excellence within the NHS. The boards of NHS trusts and other health employers must recognize and support directors of nursing to champion patient care and innovation at board level. Expertise in nursing practice has been shown to transform the lives of patients from the patient's experience^{59,60}. For example nurses working at the advanced practice level provide a significant cost-effective service in contributing to meeting health care needs with specialist and consultant nurses being linked to many innovations in care⁶¹.

Nurses are leading the Quality, Innovation, Productivity and Prevention (QIPP) programme and are illustrating how better value systems of care can be achieved whilst maximising effectiveness. Lead nurses are demonstrating how using systems as a means of making allocation decisions and improving quality can transform services. The Productivity Programme across secondary and primary care has provided evidence of how efficiencies can be achieved along with quality improvements.

The RCN believes that there are a number of pre-requisites for quality nursing care:

- 1 **Standards** about care and the environment based on shared values and evidence to provide clear expectations to all.
- 2 **Clinical leadership** enables the context and culture to sustain quality and through the supervisory role of team leaders and ward sisters who quality assure practice
- 3 **Evaluation and measurement** to demonstrate and drive ongoing quality improvement
- 4 **Sufficient registered nurses** and appropriate skill mix to enable time to care effectively.

In order to gain the support of the RCN, nurses and the wider public, the White Paper will need to explicitly address the above. This framework must show that it is built on previous successes and evidence. It will succeed or fail depending on adequate investment in appropriate staffing levels and continuing professional development. There is evidence of the negative consequences of reducing nurse numbers when regulators have investigated higher than expected levels of patient mortality.⁶² The tragic events of Mid-Staffordshire NHS Foundation Trust demonstrate what can occur when inappropriate attention is given to staffing levels, quality improvement systems and clinical governance. Nurse staffing matters because of the evidence that links patient reported outcomes to registered nurse input.⁶³ Further comments on the importance of staffing levels are included in the RCN's response to chapter 3.

Productivity in health care is both complex and political.⁶⁴ It remains a challenge to measure how improvements can be attributed to interventions by nurses. Measuring productivity in healthcare is a

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

60 *Specialist nurses, changing lives, saving money*, Published by the RCN, February 2010

61 *Maxi nurse, nurses working in advanced and specialist roles promoting and developing patient-centred health care*, published by the RCN, May 2005

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

63 Setting Appropriate Ward Staffing levels in NHS Acute Trusts, RCN Policy Unit Guidance, September 2006

64 RCN Policy Unit briefing: *Productivity and the nursing workforce*, June 2007

contentious area because increased workforce productivity is perceived by many NHS staff as a means of pushing staff to work harder for the same remuneration or as a means of reducing workforce numbers.

An example of the challenges is the current payment by results system where costs are primarily focused on medical diagnosis/interventions and not on nursing activity. Nursing costs under the payments by results system are still crudely aggregated and this results in a system for reimbursement for care that does not consider the patient's dependency on nursing. Therefore, the actual contribution of nursing teams at all levels has become invisible, despite the fact that nurses play a significant role in the quality agenda.⁶⁵

The RCN continues to call for a constant focus on person-centred, safe and effective care delivered by high quality nursing staff; the right ratio of registered nurses and skill mix as well as promoting the supervisory role of the ward sister or team leader in community settings. Nurses are in a powerful position to improve the quality of care, the experience of patients, and health outcomes across health services⁶⁶.

Engaging with staff

The Government needs to prioritise the development of engagement frameworks to support the transition and the development of clear workforce outcomes and standards, which can be used as measures/standards for providers of NHS services. In such challenging economic times it is even more important for health service leaders to communicate effectively to frontline staff what is expected to achieve the cash releasing savings and productivity gains required. This engagement and dialogue needs to be *done* in partnership with key stakeholders including trade union representative organisations.

The NHS trade unions have signed up to a set of principles for meeting quality and productivity challenges in the NHS⁶⁷. The principles were developed through the national Social Partnership Forum and the RCN strongly supports these principles to be embedded in the overall NHS strategy for making efficiency savings.

The document describes the need to build a strong partnership approach to developing and implementing the measures necessary to meet the quality and productivity challenge ahead, whilst at the same time improving services for patients.

The RCN believes it is necessary to secure the commitment and buy-in of nurses to the White Paper. Nurses are key stakeholders and much depends on the ability of the Government to win the 'hearts and minds' on their proposals.⁶⁸

Enhanced financial controls and how the NHS will manage its resources

The RCN would like to see an assurance from the Government that plans to cut management costs by 45% will exclude professional leadership roles. As discussed above, these roles are crucial not only in improving the quality of care but also in managing a period of transition.

65 RCN Policy Unit briefing: *Nursing and Payment by Results: Understanding the costs of care*, July 2009

66 *High quality nursing care – what is it and how can we best ensure its delivery?*, Policy plus evidence, issues and opinions in healthcare, Kings College London, 13th October 2008

67 *Meeting the Quality and Productivity Challenge for the NHS in Partnership* – National Social Partnership Forum (SPF jointly agreed core principles on how the NHS can work together to meet the challenges ahead, 25th February 2010

68 BMJ 2010; 341: c5032, *Why the plans to reform the NHS may never be implemented*, editorial by Chris Ham, Chief Executive of the Kings Fund published on 14th September 2010

The Government's plans to establish new commissioning consortia are likely to result in significant transaction costs over the next five years. The financial risks of shifting commissioning responsibilities to general practices do not appear to have been thought through properly⁶⁹ and success appears to be strongly dependent on how effectively consortia control finances and are prepared to make difficult decisions.⁷⁰

To ensure the effective use of NHS resources general practice commissioning consortia need to work closely with other health professionals across the care pathway and existing NHS management to develop an understanding of commissioning services in primary and acute care. In relation to White Paper's plans not to bail out failing commissioners and providers, the RCN believes that Government must consider and plan for how it will appropriately help and support commissioners and providers to ensure the sustainability of services. The announcement that the Government will provide an £18m loan to Heatherwood and Wexham Park NHS FT highlights the need to maintain both quality of services as well as financial stability. NHS Services cannot stop overnight. General practice consortia will have to take part in risk-pooling arrangements, whilst Government will need to ensure mechanisms are in place to ensure it does not lose financial control in the new structures.

Delivering the efficiency savings required by Government is challenging in itself, and pressures on staff and services will only be exacerbated by the ambitious timeframe and proposals set out in the White Paper. Many providers already have significant financial challenges to address making their ability to restructure and sustain service delivery and patient care very difficult. Any enthusiasm existing among those staff commissioning services for reform is likely to be severely affected by the day to day challenges of having to also deliver productivity savings.

The RCN's **Frontline First** campaign empowers nurses to speak out against cuts within the NHS that affect patient care, identify waste and provide innovative ideas on where savings can be made. As the campaign progresses, RCN members continue to raise numerous concerns on local trust consultations and scoping strategies, especially where staff have not been properly consulted and strategies do not incorporate an impact assessment. Information from members has indicated that very few trusts are carrying out any assessment or piloting studies to determine the impact of service cuts to provision, access and quality of care. Increasingly, NHS organisations are closing wards and deleting beds across community and acute provider services. Nurses are concerned that these changes will decrease the quality of care in the NHS.

Making savings during the transition

It is essential that NHS organisations provide support and advice for all staff that are affected during the period of transition as well as working in partnership with trade union organisations.

Since the publication of the NHS White Paper the Government has set out proposals to abolish and change several health arm's length bodies. Many of the organisations facing significant change have been instrumental in protecting and promoting good health. It is vital that their many key functions are not lost in a re-organised service. These proposals pose many questions for nurses, particularly for those currently working for the organisations affected. It would be a devastating waste of talent for the knowledge and expertise of this highly skilled workforce to be lost as services are reviewed. Public safety, quality and accountability must be at the forefront of any service changes. The Government must work closely with organisations like the RCN to ensure that reducing the number of arm's length bodies is not just about

69 Civitas Data Briefing re Government Plans to transfer commissioning responsibilities from PCTs to GPs, James Gubb, 8th July 2010
70 NHS Confederation consultation 'Liberating the NHS? Analysis and questions on the White Paper' August 2010, Issue33

cutting budgets but about delivering more efficient and safer services to the public.

The RCN notes that there is a reference to the value of the 'productive ward programme' while at the same time plans have been set out to close the NHS Institute for Innovation and Improvement. The decision to close the NHS Institute for Innovation appears to be a backward step given the strong focus on health prevention within the White Paper and associated consultation documents.

There are also numerous references to the quality of care at the same time as the Government have announced plans to close the National Patient Safety Agency (NPSA). The RCN believes that the agency has a critical role in collecting data on patient safety problems, and identifying trends and patterns of avoidable incidents as well as supporting ongoing education and learning. The RCN calls for reassurances that these important functions will continue to be provided at a national level.

There are a number of planned changes under the arms-length review where the RCN believes that further information is needed, for example the RCN believes that there is a need for clarity on how the statutory functions of the Human Fertilisation and Embryology Authority (HFEA) will continue under the planned re-organisation. There are concerns that the proposal for this area will require changes in legislation, disrupt the regulatory process and may not produce the cost savings anticipated.

Royal College of Nursing, October 2010

Appendix 1

When considering the NHS White Paper the RCN has been informed by a set of principles which demonstrate our core values – these are contained here in Appendix 1. The principles are based around the themes of quality, accountability, equality and partnership. The RCN believes that they must form the basis for the design and delivery of health and social care services.



**Principles to inform decision making:
what do I need to know?**



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Introduction

The Royal College of Nursing (RCN) has been a defender and champion of NHS Core Principles, and has used the term to underpin many of its responses to health and social care reforms.

Following a resolution at RCN Congress 2004, calling for the RCN to reject the creeping ‘privatisation’ of the NHS, it was agreed that a new expression of the NHS principles should underpin all RCN policies.

Consequently *RCN Principles: a framework for evaluating health and social care policy*, was published in April 2006 by the RCN to ‘provide a standard against which the RCN could evaluate service and policy developments, consultations and initiatives across health and social care settings and sectors within and outside the UK’. Since its publication, ‘score cards’ and other benchmarking tools have also been developed for use by local groups in specific situations, such as trust mergers.

The Fellows of the RCN, whose mission is “to improve standards of nursing care by influencing others and working through the Royal College and with those bodies that impact on nursing” have worked with the Policy Unit to update the original RCN document. This update will enable more people, in a wider range of situations, to use this document.

These revised principles serve to highlight what the RCN believes are fundamental features of the evolving role of nurses and nursing care in a modern health and social care system. The target audience for this revised publication therefore includes nurses at all levels, RCN activists from across a range of care settings, as well as policy makers interested in care and those in government.

While the original document was formulated to enable members to analyse the impacts of changes in policy on function and form of health and social care services, this updated version enlarges the focus to include, for example, the perspective of the patient. We hope this will enable RCN members to evaluate professional nursing practice within their sphere of responsibility.

What is a principle? How do I use this in practice?



The Oxford English Dictionary states:

A principle is ‘a fundamental truth or proposition serving as the foundation for a belief or action’.

The principles used in this document reflect values that underlie the definition of nursing (RCN, 2003).

Any situation can be analysed by identifying the underlying idea and the values or beliefs on which it is based. This should lead to a consideration of what type of action and what factors may enhance or hinder the outcome. It is vital that the outcome is recognised - otherwise the exercise is purely academic.

The RCN Principles can operate at a number of different levels and can also be applied to more complex situations, for example, national policy initiatives.

In short, the Principles offer a framework within which actions and outcomes may be developed and tested. The RCN considers any application of these Principles to practice should enhance the situation of all concerned.



The Principles:

1. Quality

The RCN has a long history of policies relating to the quality of care. Quality can be seen as both a technical measure and as a perspective expressed by the patient with regards to how he felt, what information was given and how people responded to him (RCN, 1989b).

Elements supporting the principle of quality

Safety

Patient safety is the first duty of the service regulators, commissioners, providers and of the individual nurse. This safety may be psychological and emotional, as well as physical in both a personal and environmental sense, applying to staff and the general public as well as the patient/client.

Dignity

Each individual is unique and must be treated with respect so that they feel they matter. Care should promote and maintain dignity at all times with particular attention paid to privacy in all aspects of care. Compassion in caring is also essential. This requires the practitioner to assess the individual's needs with empathy and sympathy and to meet those needs with sensitivity.

Patient centred care upholds the right of the patient to contribute to decisions made regarding their care and treatment. Nursing intervention should, as far as is possible, enable the patient to maintain or regain independence.

Effectiveness

This includes working to agreed standards. Standards must be based on good evidence, be measurable, achievable and realistic. Such standards are often included in policies and procedures as guidance for best nursing practice, and should also include policies and procedures in accordance with best employment standards.

In addition, patients/clients have the right to expect those responsible for their care and treatment to be effective in their practice. This requires that the practitioner be appropriately educated and trained to be able to take responsibility for their actions. It also places responsibility on the practitioner to maintain this competence by continuing professional education and working within appropriate bounds. Service providers and commissioners need to support, recognise, and invest in individuals and teams to maintain competence in a coherent, fair and sustainable way.



Efficiency

Robust systems, structures and processes support and enable front-line staff to deliver effective and patient centred care in a timely manner. Providing the right care at the right time means reducing waits and harmful delays for both those who receive and give care.

be robust and lasting. Service structures and organisational behaviour patterns should not only demonstrate good use of resources but where appropriate, use local produce and environmentally sensitive procurement.

Sustainability

Services need to be adequate for present needs as well as enable development and building capacity for the future. Planning for present and future work force needs should

Here is an example of how the RCN Quality principle could be used in practice:

Principle:	Quality.
Element:	Dignity (care environments)
Policy:	Provide bed curtains.
Evaluation:	<ul style="list-style-type: none"> • Are bed curtains actually provided? • Does the patient feel they meet their needs to provide a dignified environment? • Are they fit for purpose? (Appropriate material, size, and pattern; are they easy to launder and clean?) • What is the cost, not only of provision but of possible cross infection?

2. Accountability

Accountability means

‘being answerable for one’s decisions and actions’.

The ‘Code of Professional Conduct for the Nurse, Midwife and Health Visitor’ (NMC, 2008) states that nurses, midwives and health visitors are

“...personally accountable for actions and omissions in your practice and always able to justify your decisions.”

This includes the requirement to act lawfully, whether those laws relate to professional practice or personal life. Nurses are accountable to employers not only for their actions but also for use of resources and the reputation of the organisation.

Finally, nurses are accountable to the general public who allow them special privileges in the provision of care. Accountability presupposes the ability to accept and carry out the task and having sufficient authority to carry it out.

Elements supporting accountability

Trust

The nurse-patient relationship is founded on trust. This enables the nurse to have privileged access to the patient/client and nurses’ actions must be such that they inspire confidence in the individual and society. Corporate, financial and clinical governance within provider and commissioner organisations should inspire public confidence.

Transparency

Service providers, commissioners and practitioners should be prepared to respond to questioning regarding their actions and to be able to justify the services provided or withheld. Patient/client records which describe what the nurse has done should be open and available to the patient/client (or in special circumstances a significant other) and to staff on a ‘need to know’ basis’. The NHS is funded by public money and therefore restriction on information should be the exception rather than the norm.



Leadership

The quality of leadership has a direct impact on the quality of service provided at all levels. Service providers and commissioners should demonstrate clear leadership, and the accountability and responsibility of their leaders. Team leaders at all levels are accountable for staff in their team, ensuring that they are appropriately educated, trained and competent to undertake assigned tasks. They are also responsible for staff development and the identification and preparation of future leaders.

Confidentiality

The code which covers all practising nurses (NMC, 2008) requires the assurance of patient confidentiality. Interactions between a patient/client and staff should remain a matter of private communication within the boundaries of safety and clinical efficiency.

Patient data should only be shared on the basis of 'need to know.'

Responsibility

This is a defined area of expected action which at times may only involve monitoring; it does however require personal acceptance by the practitioner. It has to be both given by the leader of care planning and accepted by the person giving the care. In addition patient/client autonomy requires that his/her responsibility also be acknowledged. Service providers and commissioners should demonstrate their responsibility and responsiveness to the public in a transparent, accessible and democratic way.



3. Equality

The principle of equality, that is non-discrimination on grounds of age, gender, race, religion, sexual orientation and social status, is fundamental in UK society.

However in the context of individual patient care the nurse has to recognise that each patient/client has individual and unique needs and justice may require actions that are not identical.

Elements supporting equality

Equity

This requires actions that are fair and just according to the needs not only of the individual patient/client, but also the staff and the way resources are allocated. They may not be necessarily the same (equal) to those accorded in other situations or to any other patient/client.

Diversity

This is related to the element of equity. All interventions are not the same but are varied according to individual need. Service providers and commissioners should ensure that they operate on the principles of valuing and promoting diversity, and implementing equality of opportunity with

full transparency. Organisations should challenge and eradicate institutional and other forms of discrimination. Staff must have equality of opportunity within diversity.

Universality

While all interventions may not be the same, every individual should have access to care tailored to their individual needs regardless of gender, race, age, religion, sexual orientation or social status. Services should continue to be publicly funded through taxation and be available to all service users in the UK regardless of ability to pay.

Accessibility

The RCN strongly supports the principle that health care must be available to all who are in need and that such care must be provided on the basis of clinical need. The RCN is committed to reducing inequalities in access to health care. Examples of inequality of access are variations in available treatment depending on the patient's post-code, age, or social behaviour. Government policies need to be kept under review to highlight possible breaches of this principle (DH, 2007).



Advocacy

‘Speaking on behalf of another’ is an integral part of the nurse’s role. It operates at all levels from speaking for the individual patient/client to questioning national policy. Service providers and commissioners should ensure that their processes, procedures, practices and policies actively encourage - rather than exclude - public participation. This includes the right to critically feed back without hindrance on the way that services are delivered.

Here is an example of how the RCN Equality principle could be used in practice:

Principle:	Equality (England only).
Element:	Access (to primary care services).
Policy:	Use of ‘polyclinics’
Evaluation:	<ul style="list-style-type: none"> • Do the local public and professional groups recognise and agree on the problems to be addressed by building a polyclinic? • Do the services proposed clearly address and reflect local needs and concerns and enhance availability of services? • For example is the proposed clinic sited to maximise ease of access for the community it serves? For e.g. are there good public transport links? Is it a safe and welcoming environment? • What evidence or best practice is available to demonstrate that this approach will enhance access for patients?

4. Partnership

A commitment to partnership is one of the defining characteristics of nursing (*Defining Nursing* RCN, 2003) but partnership can operate on many levels:

- between the individual nurse and individual patient
- between nurses and other health professionals
- between health care, social care and increasingly a range of other services such as education, transport or local government.

Elements supporting partnership

Consultation and negotiation

These concepts are usually related to agreements about service provision or employment relations where there needs to be meaningful consultation and negotiation over service provision with trade unions, professional associations and members of the public. However these elements may be applied equally to the provision of individualised care, ensuring that the care is tailored to patient/client needs and takes account of their wishes and preferences as well as their clinical need. It is important that consultation occurs at the beginning of the interaction and not after the event.

Collaborative decision making

This is the ‘end stage’ of consultation and negotiation. Partnership is particularly important in decision making by a multi-disciplinary team regarding the integrated care of the individual patient. Nurses must be recognised as partners and fully involved in service changes and service development.

Representation

All people, whether staff or patients/clients, must have access to those who can individually or/and collectively speak on their behalf, acting as advocates who can articulate their views about policies and service development at local and national level. It is important that the availability





of such advocates is published and widely disseminated. Service providers and commissioners should demonstrate how they are actively and meaningfully engaging stakeholders (service users, carers and staff) in the design, delivery and evaluation of services, regardless of financial pressures.

Legitimacy

The legitimacy of nurses to make a contribution to patient care at individual, policy and service provision levels, based on expert knowledge, must be properly recognised. This may be at an individual level or via representative bodies.

Involvement

The public has the right to be included in all aspects of service commissioning, planning and delivery. Service providers and commissioners should demonstrate how services are developed around the needs of the public they serve, rather than the other way round. Patients and clients, if they are able, need to be involved in the planning and carrying out of their care, in addition to the requirement of giving consent. Where the patient/client is in agreement it may be valuable to also involve family members or others within a close relationship.

Here is an example of how the RCN Partnership principle could be used in practice:

Principle:	Partnership
Element:	Involvement
Policy:	World class commissioning (“engage with public and patients”) (England Only)
Evaluation:	<ul style="list-style-type: none"> • How have the primary care trusts explained to the public the Government requirements to engage with them? • Have the primary care trusts clarified what this actually means? • Do emerging structures and services facilitate the involvement of public in a meaningful way? • Do published commissioning plans reflect those locally expressed needs?

In an increasingly fast-paced practice and policy environment, we believe it is important to explore the principles which underpin new developments rather than just accept them at face value. As such, RCN Principles can be used to inspire and inform discussions around changes in nursing practice or in health and social care policy.

We would encourage members to send us their suggestions. If you have examples where the above principles have been helpful as a framework for analysis of a current policy or practice issue we would like to hear from you.

Contact us by e mailing policycontacts@rcn.org.uk or by writing to us The Policy Unit, RCN, 20 Cavendish Square, London, W1G 0RN.





References and further reading

- Bankowski Z, Bryant JH, Gallagher J (1997) *Ethics, Equity and Health for All*, Geneva: World Health Organisation.
- Davies S, Nolan MR, Brown J, Wilson F (1999) *Dignity on the Ward: Promoting Excellence in Care*. Report for Help the Aged and Orders of St John Trust, Sheffield: University of Sheffield.
- Department of Health (2001 and updates) *Essence of Care*, London: DH.
- Department of Health (2007) *The NHS in England: the operating framework for 2007/08*. Annex C: Principles of the NHS: draft for consultation, London: DH.
- Henry C (Ed) (1995) *Professional Ethics and Organisational Change*, London: Edward Arnold.
- Keyserlingk EW (1993) 'Ethics, Codes and Guidelines for Health Care and Research', in Henry C (Ed) (1995) *Professional Ethics and Organisational Change*, London: Edward Arnold, p.4.
- Nursing and Midwifery Council (2008) *Code of Professional Conduct: standards for conduct, performance and ethics*, London: NMC.
- Royal College of Nursing (1984) *What the RCN stands for*, London: RCN.
- Royal College of Nursing (1989a). *Accountability in Health Visiting*. London: RCN.
- Royal College of Nursing (1989b) *A Framework for Quality*, London: RCN.
- Royal College of Nursing (1992) *The Value of Nursing*, London: RCN.
- Royal College of Nursing (2003) *Defining Nursing*, London: RCN.
- Royal College of Nursing (2006) *RCN Principles: a framework for evaluating health and social care policy*. London: RCN.
- Rowson R. Chapter 2 in Tschudin V (Ed) (1993) *Ethics: Nurses and Patients*, London: Scutari Press.
- Tschudin V (Ed) (1993) *Ethics: Nurses and Patients*. London: Scutari Press
- United Nations (1945) *Universal Declaration of Human Rights*, Geneva: UN.
- World Health Organisation (Annually) *World Health Reports*, Geneva: WHO.



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