



Submission to the

**Prime Minister's
Nursing and Midwifery Commission
England**

August 2009

1. Introduction

- 1.1 UNISON is the largest public sector union in health with 450,000 members employed across the healthcare service. We are pleased to have the opportunity of submitting our views and those of our members to the Prime Minister's Commission for Nursing and Midwifery.

- 1.2 As the largest trade union and the voice of the healthcare team, we are instrumental at influencing policy at regional, national and international level. We work with the government and other international unions to shape healthcare. In addition we work collaboratively with other trade unions on healthcare and nursing issues. UNISON has a long history of working with organisations and individuals who work and campaign in the areas of practice and patient care. UNISON works closely with each of the professional regulators to establish standards and policies in both patient care and education. The diversity of our membership in covering the whole of the healthcare team gives us a rich source with which to gauge ideas and views from a range of professionals.

- 1.3 We hope that the commission will take into account the weight of UNISON's views as a major stakeholder and that our collective response carries the opinions of our entire nursing, midwifery and specialist public health nursing membership.

- 1.4 Whilst this is an England only submission we have also sought the views of our colleagues and members within the devolved governments to ensure the commission can engage in the widest possible way. We have always been keen to learn from best practice. In Northern Ireland we have gained experience from the way health and social care are jointly commissioned, delivered and managed. In Scotland, the pilot surrounding a regulatory model for healthcare support workers and the Flying Start programme have been of immense interest to us. In Wales we were keen to learn as much as possible from their experience in an earlier move to an all-graduate nursing commission.
- 1.5 Information surrounding the commission and its engagement has been available on our website, and it has been debated at our national health conference and at our national nursing sector committee. Our regional healthcare committees have also contributed to our submission. We jointly facilitated an engagement event with our student members in conjunction with the Royal College of Midwives and Royal College of Nursing. Our regions have facilitated local branch and employer led engagement events, which have led to a wealth of information being submitted. Finally, we have shared the work of the commission with international colleagues and trade unions, with whom we work closely.
- 1.6 We have sought to group our submission under key headings that reflect the main comments raised with us.

2. Background

- 2.1 The commission is taking evidence at a time of uncertainty within the profession and among those we care for. The current economic pressures being felt by society have had an impact on healthcare workers, with many becoming the primary earner within their family. Whilst the NHS has not so far been detrimentally affected, it's clear that nurses and midwives remain concerned about their future and the future of those they care for.
- 2.2 The last 12 years have seen unprecedented investment in healthcare and modernisation. We have seen nurses playing a leading role in the introduction of a new service in NHS Direct and the establishment of key targets. Nurses have made a vital contribution to ensuring that patients are seen and treated efficiently – this has had a major impact on waiting times for cancer treatment and stroke recovery as well as a range of other conditions. Nursing is the largest part of the NHS workforce but it pushes above its weight in its contribution to patient care. Patients have continued to rate the care they receive from the NHS as good or very good.
- 2.3 At the same time we have seen the profession aging, especially within midwifery and health visiting. We believe retirement rates and lower numbers of midwives have had a direct impact on the type of care that expectant mothers receive. Despite the vital contribution they make, many are worried about the future of the profession and, as a result, the care that patients and mothers may receive in the future.

2.4 In particular, health visitors feel that they have lost ground following the Nursing & Midwifery Council's decision to require them to maintain their part one or two registration and not to regulate them as a profession in their own right¹. We believe that health visiting should move to a direct entry profession with pathways for post-registration individuals in nursing or midwifery. This would require a change in the Nursing & Midwifery Order 2001. However, we feel that this would place the correct emphasis on child protection and development.

2.5 Finally, while the public continues to respect the founding values and principles of the NHS, people rightly demand high quality care. It is important that the profession does not stand still – it must continue to advance, evolve and develop. All of this is taking place at a time when public protection is continually questioned and challenged, and the implications for child protection and those who are most vulnerable in our society must always be placed at the heart of our profession.

3. Student nurses and midwives

3.1 While we welcome the review of student support and await the publication of the consultation, it is clear to us that this review is long overdue. Attrition rates are at an all-time high, especially within nursing. Many students are leaving because of student debt. Time and time again student surveys indicate debt as a key reason

¹ Nursing & Midwifery Council report on specialist public health nursing 2007

for considering leaving their course². The make up of students has changed: the average age of a student is now 28, more than 80% are female, and of those 54% have children or dependants they are responsible for.

3.2 We would like to see all strategic health authorities (SHAs) identify key practice development nurses and midwives to select students for their local higher education institutes (HEIs). Our student members have indicated they would have valued a nursing ‘taster’ before taking up their courses. We believe it is possible to achieve this by bringing forward the recruitment process and enabling them to have experiential learning opportunities prior to commencing their course. This would enable them to make a more informed decision regarding their future career and allow the service the opportunity to offer alternative training options within healthcare should it not prove to be their chosen career. We also believe further work needs to take place regarding clinical placements. Many students have to travel excessive distances to clinical placements and a number of them are not equipping them with the experience they need to graduate fit to practise.

3.3 We need to introduce stronger management on student attrition across each of the SHAs and HEIs. Currently there is no consistent practice or definition of attrition which leads to inconsistency in the ways it is defined at local level and managed. HEIs should undertake exit interviews on any student leaving the course for whatever reason; this should clearly indicate wherever possible the reason for leaving. This information would enable both the SHA

² UNISON 2008 student survey, a crash course out of debt

and HEI to manage attrition more effectively as well as helping to monitor quality. Both of these steps would demonstrate greater public confidence and improved management of the public purse.

- 3.4 Students should in the final six months of their programme be working full time within in an NHS organisation in the SHA. This will give them a real opportunity to ground their knowledge and develop confidence by applying their educational experience in clinical practice. In addition, it would enable them to work more closely with their prospective employer. During this period, their time in universities should be on specific days rather than block periods – for example, every Tuesday is a university or study day with specific work allocated.
- 3.5 Our student members also feel that they should be employed and salaried during their studies. While we will be exploring this during the review of student support consultation, it is clear that many students do not experience a relationship with a specific organisation as a result of their placements. We believe that this is a missed opportunity as it would enable students to see the NHS as their prospective employer. We believe that at the very least students should have a joint contract between the university and the relevant SHA who has commissioned their training.
- 3.6 Mentors for students should be given allocated time to spend with their students and specific time out of clinical duties to complete the relevant documentation effectively. Mentors must receive facilitated training from the relevant HEI to ensure they are fairly and effectively assessing students and, when necessary, not being

afraid to refuse to sign them off if they feel they are not fit for practice.

4. Nursing and midwifery

- 4.1 Nurses and midwives are the fundamental care providers of all services across all healthcare settings. We have an aging profession, with almost 20,000 leaving the register each year, either through retirement or emigration. At the same time we are not training sufficient nurses or investing in the ones we have.
- 4.2 We need a clear career pathway for all post-registration nurses and midwives to give direction and enable transparency. We need to invest in technology and equip staff with the skills to use it to make their roles easier. All community staff should have access to the internet and an electronic notebook linked into patient records, so they no longer have to carry large amounts of notes around with them. All CSSD and equipment should be able to be scanned in and out of use to ensure organisations have accurate and detailed records of stock and usage.
- 4.3 We need to invest in nurses and midwives in all bands. The aspiration of the new pay system was for people's earnings to go up as they developed and took on new roles. It was to be a lever for modernisation but this has not been executed well, as organisations have simply seen the Pound signs rather than the benefit to the service.

- 4.4 Nurses and midwives have to be allowed to make their own clinical judgement effectively and be supported to do so. We do not have sufficient nurse prescribers and all too often we limit their role and do not maximise the benefit of having this skill. All band six nurses and midwives should have the ability and authority to discharge patients at a time when they feel it is appropriate. They should be able to refer patients to all services.
- 4.5 All nurses and midwives within six months of graduation should be able to cannulate and administer intravenous medication. There should be a national protocol to facilitate this and it should be a transferable skill from organisation to organisation.
- 4.6 We wish to see more nurse-led services. They continue to be the exception in a limited number of specialities rather than the norm.
- 4.7 In midwifery we wish to see investment in staff and greater use of case loading as a system. We need more specialist midwives who are able to care for complicated pregnancies or offer more specialist advice at all stages of pregnancy and within neonatal services. Home births should be able to be a normal accommodated request for mothers. Currently this is not the case and staffing plays a significant role in this.
- 4.8 With more and more services rightly being provided in the community, we need to develop the knowledge and skills of our nursing workforce to be able to work across services and offer continuity of care for patients.

4.9 Within mental health services we would like to see more nurses taking on advance roles within the Mental Health Act. We believe that they have a vital role to play in delivering a recovery model of care.

5. Healthcare assistants

5.1 UNISON has the largest number of healthcare assistants (HCAs) in membership out of all of the unions. We have long argued for their development and recognition: providing education opportunities via the Open University, developing learning agreements with their employers and facilitating professional development through our conferences and seminars.

5.2 The role of the HCA is pivotal to the future of nursing. However, many do not feel valued and we are at risk as nurses of selling down the role of HCA in the same way as the medical profession for many years tried to limit nurses' roles and duties. It is vital that we stop this now and ensure that they are valued members of the healthcare and nursing team.

5.3 Regulation is key to this. HCAs are delivering direct and sensitive care in all settings to vulnerable patients but there are no national standards for the role or competencies. As a result there is a postcode lottery for HCAs: in good organisations there are clear standards and they are valued whereas in others there is no consistency from ward to ward or day to day. Whilst regulation has been considered as complex it is clear to UNISON that it is achievable. We believe that we need a regulatory system, which is

proportionate, and risk based. We do not agree with the Royal College of Nursing's policy statement on regulation by pay band. Pay bands bear no relevance to the roles HCAs are undertaking or where they are working and do not therefore deliver public protection.

- 5.4 UNISON would like to work with government to develop national competencies. We believe that HCAs should have ownership of them and be responsible for engaging with others to finalise them. In our experience HCAs are capable of leading this exercise with support from others, and whilst nurses should be engaged in the process they should not control it. We will help to develop core competencies which cover all areas of care, and, in addition, develop more specific ones which are service based – e.g. mental health or community care. We would then like to consult with the service on the competencies to achieve consensus.
- 5.5 We believe that gaining consensus will benefit both the individual and the service as HCAs will experience consistency in their clinical experience. We also believe it will help to make HCAs feel valued.
- 5.6 The plethora of job titles for HCAs causes concern as it makes it difficult for patients, service users and their carers to have a clear understanding of who is looking after them. Regulation would be one solution to this as it would protect any given title. Currently you can be cared for in your own home by a HCA but you can also go in to Tesco and purchase over-the-counter medication from a HCA. Job titles carry with them immense sensitivity and as a result we

wish to work with staff to develop a single title, which could be used irrespective of the setting. We would then wish to see this protected, and to have a single uniform for staff working in settings where uniforms are required to ensure consistency and clarity for those who receive care.

- 5.7 The ratio of HCAs to registrants always brings with it sensitivities. HCAs must not be used as cheap labour for their nursing colleagues and the role of the nurse must not be devalued as a result of the increase in the number of HCAs. Whilst every unit or delivery model has its own needs, patients must have a clear understanding of who is caring for them. We do not believe that this is currently achieved. In addition, staff need access to more senior support when necessary to help them care more effectively for patients. As a result we believe a staffing ratio in clinical settings of 80% nursing posts to 20% HCAs is the most sensible way forward.

6. Advance practice

- 6.1 It is unacceptable to UNISON members that the issue of advance practice and regulation remains unresolved. Currently we have a high number of practitioners who are undertaking what are considered advanced roles within practice but have no means to regulate this part of their role. As a result, there is no clear determined path or competencies for a post holder. We believe this is detrimental to public protection.

- 6.2 Advance practitioners, including nurse consultants, are welcome developments in nursing as they offer more developmental opportunities within clinical settings. However, the service does not fully recognise or value their clinical judgement. One nurse consultant in pain management is able to prescribe relief for long-term but not for acute pain – for that the doctor has to prescribe. This is a waste of a valuable commodity: the service invests in their knowledge and skills but then does not maximising the effectiveness of the investment because it places constraints on their practice. Medical consultants do not operate under this system, so why should nursing or midwifery consultants? Why are nurses' prescribing measures often controlled by chief pharmacists rather than the focus being on their clinical judgement?
- 6.3 Whilst we invest in nursing leadership we need to allow them the freedom to practise and fulfil their role, not place obstacles in their path. We would expect any practitioner who was unsure of a patient's condition or treatment to seek peer advice or support. This does not mean that we should constrain roles but with this should come clear accountability.

7. Health and safety

- 7.1 We welcome the commitment to have European legislation on safer needles and needle stick prevention. We believe that this will improve the help, support and protection which staff have a right to expect.

- 7.2 We wish to see legislation introduced which will give the same precedence to assaults against health workers as those against the police. We welcome the work by the counter fraud agency to undertake prosecutions but all too often cases fall before they come to court, primarily as there was no assessment of the patient or service user's competence at the time the assault took place. Where assaults are common more advance nurse practitioners could be trained in addition to medical staff to make an assessment of the person's competence.
- 7.3 We wish to see improved access to occupational health and health prevention for all health workers, including access to routine health promotion such as blood pressure checks, cholesterol etc. We would also like staff to be able to access on-site self defence classes. This is not to encourage them to take action but we believe community staff in particular are at risk.
- 7.4 We wish to see all security services being brought back in house and closer working relationships developed to reduce the numbers of assaults that are directed at nurses and midwives.
- 7.5 We believe that personal protection training should be mandatory for all staff and facilitated jointly by security and local police services.
- 7.6 We wish to see all managers effectively trained in supporting staff who are unwell and having a clear understanding of domestic violence to enable them to better offer help and support. It is

estimated that almost 10% of staff suffer from varying mental health conditions and are victims of domestic violence.

8. A vision for nursing and midwifery

- 8.1 We need a new modern image of nursing which encompass the variety of its roles and areas of practice – one which reflects the diversity of the profession. No longer should we allow patients to develop their view solely through Casualty and Holby City.
- 8.2 We should develop a national all-England uniform for all members of the nursing and midwifery team. This would help patients understand who is caring for them by ensuring consistency. For those working in community or mental health settings where uniforms are not worn, we should develop a clear policy of how staff should present themselves which retains the image of the profession but also protects their health, safety and well being.
- 8.3 UNISON nursing members have always argued against the use of ‘good health’ and ‘character’ by the HEIs and the Nursing and Midwifery Council. We believe these terms are too subjective and are not consistently judged. In addition, we believe the phrase ‘good health’ contradicts the Disability Discrimination Act and does not take account of the benefit which staff with different conditions bring. At the same time staff need to be able to undertake the role they are employed do to. We believe that the emphasis should be on the aims and values of the profession of treating patients with dignity and compassion.

8.4 By developing these aims and values, we believe individuals will be better able to make a more informed decision about their career choice both in schools and also as second careers, a route from which many new nurses have emerged.

9. Workforce and leadership

9.1 Leadership in nursing and midwifery is key to the successful delivery of high quality patient care. Directors of nursing are as important as directors of finance. We wish to see organisations placing ensuring that there is a nursing/midwifery seat on every NHS board, including commissioning boards. Without this we are paying lip service to leadership. It is not sufficient to say that as a board has a medical director it doesn't need a nurse or midwife. Few medical directors work full time and most retain clinical practice. We would wish to see a similar model developed for nurse or midwifery directors.

9.2 We must improve our workforce planning, and technology can help us to achieve this. We must also improve our recording information as we are failing to match new nurses and midwives to those leaving the profession. This, coupled with an age demographic time bomb, is not something we can avoid.

9.3 All nurses irrespective of their areas of practice need access to professional leadership; it has to be clear and visible. We welcome the steps which have been taken by Guys & St Thomas's Foundation Trust of back to the floor Fridays.

- 9.4 Local partnerships with trade unions are, we believe, pivotal to successful organisations but often managers are unclear of their role and the benefit that they bring. We wish to see local inductions taking account of this role and investment in staff engagement.
- 9.5 We must invest in leadership development from pre-registration. All too often individuals cannot access management training or an understanding of employment policies until they are in those positions. We believe that this is too late.

10. Helping and hindering forces

- 10.1 By far the biggest issue within helping and hindering is the culture and management style within organisations. Time and time again research tells us what makes a good organisation but we have yet to ensure that the staff satisfaction results are on a par with the patient's experience. Organisations do not take sufficient time to engage with staff and trade unions locally. Where they do there is good partnership working and a more open culture. Where they do not this failure leads to outcomes such as Tunbridge Wells and Mid Staffordshire.
- 10.2 Good managers are essential to this process, as is investment in staff. All too often economic problems have meant a suspension of education and training and even in some cases mandatory training. Good managers oversee staff attendance and performance effectively. Good managers ensure that all of their staff feel valued and recognised for the contribution they make. Good managers are

respected by their staff and deliver good outcomes for patient care and their organisation.

10.3 We believe that all managers, irrespective of their post, should go back to the floor on a regular basis – if not weekly then monthly. This time should be protected to ensure that it takes place.

10.4 Organisations should manage poorly performing managers as effectively as they manage any other member of staff, All too often they are managed out and the problem becomes some other organisation's.

10.5 Nurses and midwives have expressed significant concern over staffing levels. In UNISON members' experience, employers have cut the number of band six posts, often reducing staffing to one band 7 and two if not one band 6 posts per ward. It has been done on the back of a skill mix review, but the rationale has often been more economic as organisations have felt Agenda for Change is too expensive and as a result they cut posts. It appears that nursing and midwifery are easy targets, being the largest part of the workforce. Organisations have not cut the number of medical or consultant posts in the same fashion, so why nursing?

10.6 UNISON supports skill mix reviews as an effective way of ensuring organisations have the right staff with the right skills in the correct areas. However this should never be about money. It should always be about patient care outcomes and delivering quality services. We do not achieve this if we remove the very people providing the direct 24/7 care.

11. Comments from members during the consultation

(For ease of use we have grouped these under three headings)

Ideal nurse or midwife, knowledge skills and attributes

- It is quite easy to list ideal attributes and values but to some extent this can distract us from key issues, or lead us to blame individual nurses for service failings or problems in individual encounters with service users.
- Kindness and compassion are attributes valued by nurses and patients alike (and by Lord Darzi's review); but their absence may not be just about the personality of nurses and can reflect the context in which people work – especially resource and workforce issues.
- The ideal nurse/midwife is a 'craft' worker, who is autonomous and able to work effectively at all stages of a care episode/encounter. She/he should have continuity of involvement in care through all stages of planning, execution and evaluation.
- To accomplish this, nurses must be valued and respected by other disciplines within the team, notably medical professionals.
- The ideal professional 'status' is one which sees patients/service users and informal carers as true partners – professionalism should not distance the practitioner from the user. Nursing professional status should not be taken for granted just because we can speak of it. We need to think in detail about the form of our professionalism, and reject outdated archetypes developed in the

legal and medical professions which reify and claim monopoly over 'expertise' at the expense of the laity. There are also important gender issues at stake, especially the need to overcome a historical denigration of nurses' work as mere 'domestic labour' (see the work of Jane Salvage of the Florence Nightingale School of Nursing and Midwifery, King's College London, and of Celia Davies of the National Institute for Health Research).

- Adequate pay and terms and conditions are important in demonstrating true professional status.
- Registered nurses' relations with support staff are also important. Nurses should not replicate iniquitous aspects of their relations with other more esteemed disciplines in their dealings with HCAs. Nor should there be a devaluing of hands-on care, only to be delegated to the lower paid. Nursing care as practised by registrants must be about direct care.
- In terms of knowledge, nurses must be prepared to be critical thinkers. This is much more than being prepared to administer increasingly technical interventions and technologies.
- Nurse training should emphasise critical thinking skills and relate these where possible to empathic and compassionate understanding of human behaviour. There are some interesting examples of utilising the wider humanities in the training of healthcare practitioners which could be expanded. This latter point is important in the context of pressure on university resources, where the humanities are becoming increasingly squeezed by an emphasis on physical sciences.

What would we like to see nurses doing more of?

- Nurses to get more opportunity to demonstrate their analytic, critical thinking skills in the planning and organisation of their day-to-day work and through input into wider strategic decision making, both at the level of team working and policy formulation. This relates to the above comments on mutual esteem between professions.
- More nurse-led services and initiatives, better placed to deliver holistic philosophies of care – e.g. long-term conditions management, mental health crisis houses, and elderly care.
- Better support for leadership and management – but this to be cast in more progressive philosophies – co-operative, horizontal (non-hierarchical), participatory and democratic.
- More nurses active in the political arena – nationally and at community level. This to involve dynamic engagement and participation in their trade unions,
- Nursing politics to connect with progressive values – and clearly exclude the reactionary politics and racism of the likes of the BNP. This should be addressed explicitly by Nursing and Midwifery Council code of professional conduct.
- Public health agenda advanced by dynamic practitioners thoroughly engaged within local communities and supported to do so. Needs a greater emphasis on resource allocation to such initiatives.
- More interest in nursing internationalism – needs institutional developments to support nurses interested in activity to support internationalism – e.g. exchanges.

Constraints on nursing practice now

- The way in which nurses' work is organised is very important. If the management or organisation of work is hierarchical and diminishes the autonomy of nurses, or limits their ability to be involved in a process of nursing (being involved in all stages of care, rather than task allocation, or even supervision of others e.g. HCAs), then this is a recipe for diminished job satisfaction or fulfilment (see Braverman (1974) *The Degradation of Work*). In this thesis one can see a tendency for neoliberalism and managerialism leading to systems of working that increasingly resemble the division of labour of production lines, rather than the expression of craft working.
- Dominance of bio-medicine as overarching organising philosophy.
- Narrow models of management.
- Political economy: marketisation and privatisation in the context of worsening economic conditions.
- Threats to the public image of nursing – media coverage and stereotypes.
- Poor workforce planning – or the need to expand the nursing workforce constrained by overall spending constraints, complicated by resource pressure in the university system. The capacity to renew the workforce is a big question (and also relates to international issues re global nursing workforce).
- We must resist attempts to attenuate the contribution of registered nursing to a knowledgeable supervisory role, accomplished with fewer staff.