

## Health & Social Services Committee

### HSS(2)-08-05(p.1a)

Date: Wednesday 22 June 2005

Venue: Committee Room 2, National Assembly for Wales

Title: Nursing Issues - Evidence from the Royal College of Nursing

This RCN Wales paper highlights the issues affecting the nursing profession and should be viewed within the context of the following documents:

**Realising the Potential** (NAW 1999) **The Future Vision** (RCN Wales 2005), **2015: A Picture of Health** (NHS Confederation 2005) and **Designed for Life** (WAG 2005). The issues that we have chosen to highlight in this paper are either those that RCN Wales believes represent strategic themes of nursing policy that the Committee will see consistently re-emerging across different health policy fields or they are issues that RCN Wales believes require urgent and pressing attention of the Committee.

#### **Section 1 - Recruitment and Retention**

Recruitment and retention is an essential field of health policy. No policy of improvement to public health or of service can be implemented or designed without an adequate consideration of the professional skills and roles that are needed to be in the right place at the right time. There are very specific issues of recruitment and retention for the nursing profession. These issues form the policy context in which **Realising the Potential** and **Designed for Life** must be viewed.

#### **Section 2 – Pensions**

Pensions are an integral part of any workforce development policy. The Welsh Assembly Government in conjunction with the UK Government is considering significant change to the NHS pension scheme.

#### **Section 3 - Agenda for Change**

Agenda for Change has not only redesigned pay scales and the terms and conditions of NHS employment but more fundamentally impacts on how skills and knowledge are gained and on career pathways. In delivering improvements in patient care and in developing primary care and public health, Agenda for Change is a powerful tool.

#### **Section 4 - Emergency Care**

Emergency Care is a particular field of acute care that has until recently been neglected by national health policy development. For nurses working on the frontline of emergency care there is certainly a corresponding perception that emergency care has become a low operational priority. The nursing profession not only delivers a significant amount of this emergency care it is in the position of having the potential, *if* this is developed, to be able to deliver innovative solutions to some of the difficulties. The Royal College of Nursing in Wales feels that the Health and Social Service Committee of the National Assembly for Wales could achieve much in retaining a focus on this field.

### **Section 5 - Advanced Roles for Nurses**

The nursing profession since its conception has focused on research, the development of practice and advancing patient care. Wales has led the way in some of these developments. It is essential for both the nursing profession in Wales and the public that Wales contributes to the furthering of patient care through research and the development of advanced roles.

### **Section 6 - Abolition of Health Profession Wales and transfer of functions to National Leadership Innovations Agency for Healthcare**

The abolition of Health Profession Wales and transfer of functions to National Leadership Innovations Agency for Healthcare is proceeding apace. These functions are integral to assuring the quality of nurse education both pre and post registration and therefore are crucial to patient care.

### **Section 1 - Recruitment and Retention**

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The RCN believes that an annual analysis should be published showing nursing retention rates, turnover, retirement, transfers to other NHS employment and moves into the independent sector across Wales.

The RCN believes that arrangements for determining shift patterns and shift allocation should be reviewed. Reforms should seek to maximise the degree of choice and control that individual nurses have over their working hours. Particular attention should be given to the experience of new entrants to the profession in their first 5 years.

The RCN believes that the number of excess hours nurses are working should be monitored and targets should be established to reduce these.

The RCN believes that the Code of Practice for NHS employers involved in the international recruitment of healthcare professionals should be made mandatory across the public, private and independent sector.

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The RCN believes the full implementation of Agenda for Change must remain the priority of Government and health agencies.

The RCN believes that unsocial hours should be rewarded appropriately.

The RCN believes that:

There needs to be ring-fenced funding for the introduction of appraisal, staff training and the required learning needs (this has been done for the medical professions).

Every ward and department should have a learning representative.

The RCN believes that the HE sector need to recognise the professional nursing aspects of the nurse educator role and the Pay Framework needs to address this.

The RCN believes that every effort should be made to encourage the sign-up of independent contractors to the NHS and employers in the independent sector to A4C.

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The RCN believes that Welsh Assembly Government guidance should be issued to NHS Trusts outlining the standards expected to secure the safest possible environment in which to work and the support staff should be able to expect.

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The RCN believes that the Welsh Assembly Government and health agencies should promote nurses in advanced roles and put in place support mechanisms to encourage such development.

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The RCN believes that there should be a professional nursing lead within the leadership development programme and within the Workforce Development Education and Commissioning Unit.

## Nursing Issues

### **The Royal College of Nursing**

With a membership of over 380,000 registered nurses, midwives, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional body and trade union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The Royal College of Nursing represents nurses and nursing, promotes excellence in practice and shapes health policies. This is our mission as an organisation. We exist to:

Represent  
Influence  
Support and Protect  
Develop  
Build

### **RCN Wales – The Voice of Nursing in Wales**

RCN Wales represents over 21, 000 members. The Royal College of Nursing in Wales has a proud history behind it. The first All Wales meeting of Welsh Nurses was held in 1959. The first Welsh Board of the RCN was convened in 1962 with our headquarters were established in Cardiff in 1965. In 1999 RCN Wales was one of the first health organisations to engage constructively with the National Assembly for Wales. We have a proud tradition in working in partnership, advising on professional matters, campaigning for improved public health and in representing the interests of our members in order to enhance the patient experience.

### **Rationale for the Nursing Issues highlighted in this paper**

The Royal College of Nursing of Wales is pleased to receive this invitation from National Assembly for Wales Health and Social Services Committee. As members of the nursing family our goal as individuals has always been to care for and improve the health of our patients. RCN Wales is committed to contributing to the development of Welsh health policy and to improving the health of the whole nation.

As the Committee will be only too aware there are many issues affecting the nursing profession today. The modernisation of the workforce is bringing new opportunities for professional development while the global health market and demographic changes are bringing new health challenges.

In July 1999 the National Assembly for Wales published **Realising the Potential**, its Strategy to bring Nursing in Wales into the 21st Century. This document clearly set out the thematic standards the nursing profession within Wales needed to achieve in order to both realise our full potential and to meet the needs of our patients.

The five key themes of the report were:

- Improving the environment of care.
- Ensuring high quality services for all.
- Encouraging independent and reflective practice.
- Developing existing career and new career paths.
- Demonstrating the value of nurses.

Realising the Potential was further developed in seven key briefing papers:

- Briefing Paper 7: "Realising the Potential - Nurturing the Future"
- Briefing paper 6: "Realising the Potential - Achieving the potential through research and development"
- Briefing paper 5: "Realising the Potential" - Principles to Practice" A framework for Realising the Potential of Child and Adolescent Mental Health Nursing in Wales
- Briefing Paper 4: "Realising the Potential - Delivering the Future in Wales" A Framework for Realising the Potential of Midwives in Wales.
- Briefing paper 3: "Realising the Potential - Inclusion, Partnership and Innovation" A Framework for Realising the Potential of Learning Disability Nursing in Wales
- Briefing paper 2: "Realising the Potential - Aspiration, Action, Achievement" A framework for realising the potential of mental health nursing in Wales
- Briefing paper 1; "Realising the Potential: "Creating the Potential - A Plan for Education"

In January 2005 we published **RCN Wales: The Future Vision**. This included a commitment for RCN Wales to campaign around the central themes of:

- Public Health
- Improving the Health Service
- Increasing Access to Healthcare.

In March 2005 the NHS Confederation alongside many other health organisations including the Royal College of Nursing launched **A Picture of Health 2015**. This document outlines what the NHS and the wider health system could look like in 2015. It describes a health system which has as its main features:

- Improving health as well as treating sickness.
- Better care for patients in their communities.
- Team-working and technology.
- New roles for hospitals –working differently, working together

**Designed for Life** was published by the Welsh Assembly Government in May 2005. Building on **Improving Health in Wales** (2001), this strategy reasserts the Government's commitment to developing a truly national health service for

Wales and how they will do it. The emphasis is on a vision of how Wales's health services should look in 2015, on continuing the partnership approach and on the development of a new planning system "that will rapidly improve performance across Wales - one that will ensure we make the best use of all the talents and resources available, no matter where they are.". Three strategic frameworks are to govern this process:

- Strategic Framework 1: Redesigning Care 2005-08
- Strategic Framework 2: Delivering Higher Standards 2008-11
- Strategic Framework 3: Ensuring Full Engagement 2011-14

RCN Wales has welcomed the publication of *Designed for Life* as providing a clear direction solid for policy development and implementation which will over the next 9 years redesign the health service in Wales. It is the intention of RCN Wales to contribute to this national process of health policy formation.

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- <sup>1</sup> There has been welcome growth in nurse staffing levels over recent years in Wales. Since 1999 there has been a 12% increase in nursing levels in the NHS in Wales. The in-training nursing population in Wales has also risen. In 1999 there were 2,573 students. By 2002, the latest year for which figures are published, the figure had increased to 3,454. Furthermore **Designed for Life** has set a growth target of an extra 6,000 nurses for 2010.
- <sup>2</sup> This growth in staffing levels is set however against a period of almost unprecedented change and development in the delivery of health care in Wales. National Service Frameworks and other significant policy vehicles have been developed, there has been substantial structural re-organisation and new policy targets have been set. Throughout this period the nursing profession in Wales have continued to deliver first class patient care.
- <sup>3</sup> In November 2004, the RCN's fourth annual labour market review **Fragile Future** revealed that whilst overall numbers of nurses have grown, this growth masks an unstable and unsustainable demographic, characterised by an ageing workforce, reliance on temporary staff and internationally recruited nurses.
- <sup>4</sup> There is an increasing reliance on bank and agency nurses. NHS spending on agency nurses, stood at £628m in 2003, almost triple the amount spent in 1997. In Wales the figure is £21m in 2003/04 compared to £10m back in 2000/01, an increase of 117% over three years.
- <sup>5</sup> Similarly, the continuing reliance on internationally recruited nurses was confirmed with a five-fold increase in the numbers of nurses entering the UK over the past few years. 40% of nurses entering the British health system were trained abroad.

**Table 3: Initial entries to the NMC effective Register from pre-registration nursing and midwifery training in the UK, 1990/91 to 2003/04 by country**

	England	N.I.	Scotland	Wales	UK
<b>1990/91</b>	14786	659	2537	998	18980
<b>1991/92</b>	14184	726	2513	846	18269
<b>1992/93</b>	13931	717	2485	936	18069
<b>1993/94</b>	13992	707	2334	915	17948
<b>1994/95</b>	13997	585	2060	769	17411
<b>1995/96</b>	13527	581	1920	842	16870
<b>1996/97</b>	11208	492	1802	708	14210
<b>1997/98</b>	9416	437	1688	541	12082
<b>1998/99</b>	10184	421	1789	580	12974
<b>1999/00</b>	11048	363	1909	715	14035

<b>2000/01</b>	12501	379	1771	782	15433
<b>2001/02</b>	11712	393	1786	647	14538
<b>2002/03</b>	na	na	na	na	18216
<b>2003/04</b>	15862	457	2331	812	19462

Source: UKCC/ NMC annual reports; disaggregated data not available for 2002/3

- <sup>6</sup> The Office of Manpower Economics' survey of NHS employers (England & Wales) found that 45% of employers reported that they had "quite a problem" recruiting nursing staff. The Commission for Health Improvement noted in its review of mental health services that "significant staffing shortages, primarily of psychiatrists and inpatient nurses have a major impact on clinical leadership and the quality of care".
- <sup>7</sup> While staffing growth targets have been the focus of policy attention the fundamental objective in increasing the number of NHS nurses is to improve the provision of care to patients. There is a growing evidence base on the links between low staffing levels in nursing and a range of negative care outcomes. These include: increased mortality rates; adverse events after surgery; increased incidence of violence against staff; increased accident rates and patient injuries; increased cross-infection rates; and higher rates of pneumonia, upper gastrointestinal bleeding, shock/cardiac arrest, and urinary tract infections.<sup>i</sup>
- <sup>8</sup> The recent National Audit Office report on the incidence of hospital-acquired infections in England and Wales also highlighted the possible link between increased incidence of MRSA with staffing shortages, higher use of temporary staff, and skill dilution. It noted that: "Despite the overall increase in the number of clinical staff working in the NHS, staff shortages and reliance on temporary agency staff is a continuing issue for many trusts, particularly in London. Both have been shown to impact on good infection control, as does the increased use of unqualified staff."

### **NHS vacancy rate**

- <sup>9</sup> At 30 September 2004 1,267 NHS posts in Wales had been vacant for three months or more. The number of vacancies in Nursing, Midwifery and Health Visiting was significantly larger than any other:

553 in Nursing, Midwifery and Health Visiting  
201 in Medical and Dental  
145 consultant posts  
93 in Allied Health Professionals  
80 in Scientific and Technical

- <sup>10</sup> This reported vacancy rate (whole time equivalent) is not however a measurement of the number of nurses needed to fulfil the current workload. There has not yet been a national workload measurement evaluation of the skill mix of qualified nurse to patient dependency. A simple extrapolation from the amount expended on agency nursing reveals the equivalent of a further 1,500 wte nurses employed to meet the current workload. 67% of Nurses surveyed by the RCN in 2003 feel that staffing levels are insufficient to provide a good standard of care

## Wanting to leave the profession – Retention

- <sup>11</sup> There is no accurate or easily available estimate of the overall retention rate of NHS nurses at UK or national level. The only source with any trend information is the annual survey conducted by the Office of Manpower Economics (OME). This survey examines the number of nurse joiners and leavers.

### Wastage rates % NHS registered nurses March 2003 by country

Great Britain	9.2%
Wales	6.6%
Scotland	11.0%
England	9.1%

- <sup>12</sup> There is no indication of significant improvements in the annual wastage rate in recent years. This rate includes retiring nurses.

The RCN believes that an annual analysis should be published showing nursing retention rates, turnover, retirement, transfers to other NHS employment and moves into the independent sector across Wales.

- <sup>13</sup> Since 1993 the Annual RCN Employment survey has asked nurses to indicate the extent to which they agree or disagree with the statement *I would leave nursing if I could*. Expressing this view can be seen as a culmination of negative career and job experiences, and provides a broad indication of general morale.
- <sup>14</sup> This year 32% of NHS nurses (29% of all nurses) said that they would leave nursing if they could. Five years ago this figure was 27%. Moreover one in nine nurses is planning to leave nursing within the next 2 years.
- <sup>15</sup> The retention challenge facing the NHS today is to improve the quality of work life early on in nurses' careers. This is the point when the majority are working in the NHS, and form their opinion about whether it will be the right workplace for them later in their careers.

## Workload Patterns and Retention

- <sup>16</sup> The RCN Working Well survey 2002 reported that 43% of all nurses are not working the shift pattern they would like to. Surveys of RCN members have found that half of those who recently left the NHS said that having greater flexibility in working hours would have encouraged them to stay. Having sufficient choice and control over the hours worked is clearly an issue affecting retention.
- <sup>17</sup> Working hours are also an important factor in deciding to return to nursing once having left. In the NHS Executive's return to nursing survey (England), suitable working hours is the most frequently cited single measure that would encourage nurses back into nursing. The 2003 RCN annual employment survey (UK) found that the most important factor (cited

by 54%) in attracting nurses back to work after a break was the availability of suitable working hours.

**Hours, Earnings and Dissatisfaction**

63% of NHS full-time Nurses work excess hours on a regular basis

Nurses average working hours full-time - 44 hours

Nurses average working hours part-time - 28 hours

25% of Nurses (44% of BME Nurses) also work at a second job

Average additional weekly hours spent on a second job - 10 hours

67% of UK Nurses earn at least half of total household income

74% of Welsh Nurses earn at least half of total household income

53% of Nurses work a full internal rotation (early, late, night)

68% of Nurses seriously dislike internal rotation

39% of Nurses on internal rotation would leave the profession if they could

29% of Nurses would leave the profession if they could

*Source: RCN*

- 18 There is a clear relationship between stage in career and shift patterns, **over and above the relationship with domestic circumstances**. For example, 57% of staff nurses in the NHS work a rotating shift pattern, but this figure is 73% for those in the first ten years of their careers, 44% for those with 11 to 20 years experience and just 39% for those with more than 20 years experience.
- 19 Again, this points to the intensity of the work experience of nurses in the early stages of their careers, while they are in the NHS. In the first five years after training, nurses are likely to be working full-time, on internal rotation in an NHS hospital.
- 20 In the RCN membership survey 2003 58% of respondents reported working hours in excess of their contracted hours. More than six out of ten (63%) full-time nurses worked in excess of contracted hours in their last full working week. A half (51%) of part-time nurses worked extra hours. Full-time nurses in independent care homes are most likely to work more than their contract hours (70%). Nearly a half of all full-time nurses (49%) work extra hours several times a week or more and 31% of part-time nurses work extra hours this frequently.
- 21 Working hours as the key reason to leave nursing or return. Where nurses have greater control and choice over their working patterns they feel more valued and less likely to want to leave nursing. Areas of nursing that provide this flexibility in working hours and patterns not only retain nurses in greater number, but also attract more experienced nurses. The RCN would like to see flexible working patterns available to all staff.
- 22 New research in the USA has also found that the risks of nursing staff making errors was significantly increased when shifts were longer than 12 hours, when nurses worked overtime, and when nurses worked more than 40 hours per week.<sup>ii</sup> This is a significant health and safety issue for patients.

- <sup>23</sup> On 11 May 2005 Members of the European Parliament rejected the European Commission's proposal of an opt-out clause to the Working Time Directive allowing people to work more than 48 hours in an average week. The European Commission countermanded this decision by issuing an alternative proposal that allows the opt-out clause to remain in place until 2012 and thereafter for member states to be able to request an extension. The Council of Ministers were unable to reach an agreement on this issue and therefore the matter did not proceed to a vote. The UK Government leads a group of member states who are determined to retain the opt-out clause. The RCN along with our pan-European alliances lobbied those UK politicians attending the Council of Ministers to alert them of nurses concerns that working long hours endangers patient care, patient safety and adversely affects their own health and safety.

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### **Career Opportunity and Retention**

- <sup>24</sup> As might be expected, desire to leave nursing is closely correlated with the other attitude items covering nursing as a career and job satisfaction. For example, nearly three-quarters of those who would leave nursing if they could (74%) say that career prospects are becoming less attractive and more of these nurses do not know where their career in nursing is going.
- <sup>25</sup> E grades make up 35% of the NHS workforce, and more than any other grade they are likely to say that they would leave nursing if they could. The 2003 RCN membership survey results found that a significant proportion of E and G grade nurses had been on the same grade for ten years or more. These nurses (47% of all respondents) are the most likely to feel that their grade is not appropriate to their role and responsibilities, and are planning to leave nursing within two years. Of concern is that as nurses spend more time on their current grade they increasingly feel that their employer does not value efforts to upgrade their skills.
- <sup>26</sup> Approximately one-in-eleven respondents say that, at the time of the survey, they were acting up to a higher grade. Across all the nurses acting up to a higher grade four out of ten (39%) say in the survey that they are paid for doing this. However, again it seems minority ethnic nurses are less likely to be paid for acting up a grade (18% compared with 44% of white respondents).



- <sup>27</sup> Whether or not grade is considered appropriate is the factor that correlates most strongly with nurses feeling valued. Where respondents think that their grade is appropriate to their role and responsibilities nearly two-thirds (64%) agree that their work is valued. On the other hand where nurses do not feel their grade is appropriate only 45% feel that their work is valued.
- <sup>28</sup> There are also a significantly higher proportion of Welsh nurses (53% compared with 48% across the UK) remaining on at the top of their incremental grade rather than moving upwards. There are only 23 appointed nurse consultants in Wales for example out of 55 approved posts. This may be a reflection of pressure within the Welsh NHS to flatten the nursing structure and reduce the number of higher paid senior nursing positions. Clearly this would have an impact in retention and morale.
- <sup>29</sup> Minority ethnic nurses are much more likely than white nurses to say that they would leave nursing if they could (45% compared to 28% of white nurses). Ethnicity is one of the key variables correlated with desire to leave nursing.
- <sup>30</sup> It is clear that the importance of A4C is lies in its potential ability to addressing these issues of career development and retention.

### **An Ageing Workforce**

- <sup>31</sup> A key shift in the nursing and midwifery population in recent years has been the ageing profile. In 1991 one in four of all practitioners on the register was aged under 30. But, by 2002/2003 only one in eight was under 30. Furthermore a quarter of all nurses, midwives and health visitors on the UK register are aged over 50 years old.
- <sup>32</sup> The significance of this age-shift is threefold:
- a. the numbers of registrants leaving the register is bound to increase as the large cohorts of nurses aged 50-plus age over the decade. It has previously been reported that the peak years for leaving the register are 35 to 39, and 60 to 64
  - b. fewer of the older nurses who remain on the register are likely to participate actively in the nursing labour market
  - c. older nurses who do participate are less likely to work full-time. The 2003 RCN membership survey reported that the proportion working full-time fell from 86% of nurses aged under 30, to 54% of those aged 50 or older.

### **Bank and agency nurses**

- <sup>33</sup> Nurses working in this sector as their main job commit on average 24 hours a week, which is about the average for part-time nurses working for other employers. Working for a nursing bank or agency work does not mean moving out of the NHS environment, as most (60%) work in hospital-based settings in adult general or critical care.

- 34 Nurses working for banks and agencies are thus working in roughly the same settings and for the same number of hours as part-time nurses employed directly by the NHS, which emphasises the importance of choice and control for nurses choosing this mode of work.
- 35 Bank and agency nurses are no more or less likely than other nurses to have children living at home, have other caring responsibilities or to live with a partner.
- 36 Bank and agency work is more commonly undertaken in addition to a main job.
- 37 The latest figures available on nursing agency expenditure in Wales (from the Healthcare Financial Management Association Wales Report) show an annual expenditure of £21m in 2003/04 compared to £10m back in 2000/01 an increase of 117% over three years.
- 38 This rise is mirrored in the expenditure on bank nursing, with expenditure increasing by 82% in the last 3 years from £16m to £30m per annum.
- 39 Out of the total spend of £50m per annum on temporary nursing in Wales, approximately £15m - £20m of this represents the premium cost of a temporary nurse compared to a substantive nurse. This in effective means that at least 50% of the expenditure on temporary nursing in Wales could be saved or redirected into the service to improve the quality. The HFMA report comments that it is “even more disheartening is that the majority of this premium is finding its way into private company profits rather than into NHS services or nurses pay packets.”

### **International Recruitment and International Outflow**

- 40 The UK is major player in international nursing labour market. We compete with other developed countries such as the USA, Australia, Ireland and Canada, which are also facing demographic-related nursing shortages. The limited international data that is available suggests that the overall trend in international flows of nurses is increasing. This is, in part, driven by active recruitment of nurses from developing countries to the developed world.

**Non-UK initial admissions as a % of all initial admissions to the UKCC/NMC register,**

<b>Year</b>	<b>as % of all initial admissions</b>
1993/1994	11%
1994/1995	12%
1995/1996	14%
1996/1997	21%
1997/1998	26%
1998/1999	28%
1999/2000	35%
2000/2001	39%
2001/2002	53%

2002/2003  
Source: NMC

43%

- <sup>41</sup> Work permit data highlights the continued reliance on the Philippines, India and South Africa. The Philippines alone has accounted for more than one in three permits issued annually. India has increased in importance as a source country. The number of approved applications from India doubled from 2,418 to 4,802 between 2001 and 2003.
- <sup>42</sup> The HFMA in Wales has produced a report which noted the increased pressure on nurses as a result of mentoring and support needed for overseas nurses brought into Trusts across Wales. Preliminary data identified over 750 nurses joining Welsh NHS Trusts between September 2000 and September 2003, with even more joining during 2004. This report noted that without international recruitment over the past few years there would have been a considerable reduction in the quality and range of service offered to patients. However, the report also noted that many hospitals feel this method of recruitment has been exhausted given mentoring pressures, language barriers and more importantly vacancy levels increasing at the higher grades which many internationally recruited nurses do not generally offer.
- <sup>43</sup> Using international recruitment as a means of meeting NHS nurse staffing targets has not been without controversy. Some commentators have raised the impact of international recruitment on developing countries as an issue. The RCN has highlighted the discriminatory practices and misleading information provided to some internationally recruited nurses. The NMC has joined with the Philippine Embassy in London to warn Filipino nurse recruits about dubious practices by some recruitment agencies, which charge inflated prices and provide misleading information. In particular, it appears that such practices occur disproportionately in the independent sector.

#### **Internationally Recruited Nurses and Retention**

29% of Nurses plan to leave their current employer within 2 years  
45% of IRN's plan to leave their current employer within 2 years

29% of Nurses who would leave nursing if they could  
36% of IRN's who would leave nursing if they could

Source: RCN

- <sup>44</sup> To combat some of these criticisms, the Department of Health introduced a code for international recruitment in 2001 (on this issue the DoH acts as the lead for the Welsh Assembly Government). This code requires NHS employers not to recruit actively from a list of developing countries published in 2003, unless there is a country-to-country agreement such as with the Philippines, India and Indonesia. Also, they must use recruitment agencies from a preferred provider list. The code emphasises that international recruitment is "a sound and legitimate contribution to the development of the NHS workforce".

<sup>45</sup> The major limitation of the code is that it does not cover the independent sector, which continues to recruit from countries on the proscribed list. It should be noted that about one in four new overseas registrants to the NMC in 2002/2003 had come from developing countries on the banned list. More than 2,800 nurses came from Sub-Saharan Africa.

The RCN believes that the Code of Practice for NHS employers involved in the international recruitment of healthcare professionals should be made mandatory across the public, private and independent sector.

<sup>46</sup> The UK cannot ignore that it is part of a broader international labour market for nurses. English speaking nurses have a range of career opportunities in OECD countries in North America and Australasia. The USA has quantified its nursing recruitment need as being in excess of 1 million registered nurses between now and 2012, including 623,000 to fill newly created jobs. The Canadian situation has been quantified as a shortfall of around 78,000 nurses by 2011. Australia projects a shortage of 40,000 nurses by 2010. Most countries are now heavily into looking for policy solutions to address these shortage problems.

<sup>47</sup> The UK has exploited its market advantage in recruiting English speaking nurses from Africa and Asia, but it will be the target for increased recruitment activity from OECD countries attempting to solve their own nursing shortages. There are already signs that recruitment of nurses from the UK to the USA is becoming more significant.

**Number of NMC verifications issued to destination countries 2002-03**

Australia	2,602
USA	2,224
European Economic Area	1,622
New Zealand	958
Canada	452
Africa	29
Others	192
<b>TOTAL</b>	<b>8,079</b>

Source: NMC

## School Nursing

<sup>48</sup> School nursing is a policy priority for the RCN because of its potential contribution to the public health agenda. This field has relatively few nurses - only 150 wte throughout Wales. Most are recorded as first level nurses, which means that they are not qualified specifically in school nursing

## School Nurses

Trusts	WTE		Total
	Without Qualification	With Qualification	
Bro Morganwg	4	5.16	9.16
Cardiff and Vale	7.45	19.25	26.7
Carmarthenshire	6.3	0	6.3
Ceredigion	3	3	6
Conwy and Denbigh	9.37	2.4	11.77
Gwent	20.76	3	23.76
North East Wales	19.27	5.04	24.31
North Glamorgan	3.8	3.76	7.56
North West Wales	9.7	1.8	11.5
Pembs and Derwen	4.48	2.24	6.72
Ponty and Rhondda	7.84	0	7.84
Powys	5.82	1.4	7.22
Swansea	1	0.6	1.6
Velindre	0	0	0
<b>Total</b>	<b>102.79</b>	<b>47.65</b>	<b>150.44</b>

The RCN believes that number of whole time equivalent school health nurses in Wales needs to be increased

## Executive Summary Section 1 - Recruitment and Retention

The RCN believes that the recent increase in overall nursing numbers is to be welcomed. However the vacancy rate in the NHS in Wales and the increased expenditure on temporary nursing staff demonstrate a need to build a sustainable workforce and to increase retention rates.

The RCN believes that an annual analysis should be published showing nursing retention rates, turnover, retirement, transfers to other NHS employment and moves into the independent sector across Wales.

The RCN believes that arrangements for determining shift patterns and shift allocation should be reviewed. Reforms should seek to maximise the degree of choice and control that individual nurses have over their working hours. Particular attention should be given to the experience of new entrants to the profession in their first 5 years.

The RCN believes that the number of excess hours nurses are working should be monitored and targets should be established to reduce these.

The RCN believes that the Code of Practice for NHS employers involved in the international recruitment of healthcare professionals should be made mandatory across the public, private and independent sector.

The RCN believes that number of wte school health nurses in Wales needs to be increased

## Section 2 - Pensions

- <sup>49</sup> The Government is currently reviewing the public sector pension schemes, including the local government scheme, the NHS scheme, the teachers' pension scheme, the police and fire service schemes and the civil service schemes. The NHS Pension Scheme consultation closed in April 2005. A submission will be made to the Minister of Health in early summer 2005.
- <sup>50</sup> At the end of April 2003 the NHS Confederation, on behalf of NHS employers and in conjunction with the Department of Health, the NHS Pensions Agency and the National Assembly for Wales, commenced a review of the NHS Pension Scheme. Similar processes are being followed in Scotland and Northern Ireland. The overriding aim of the review is to ensure the NHS Pension Scheme meets the needs of a modern NHS and its staff by making benefits more appropriate for today's workforce and also to consider the Government proposal to increase the normal pension age to 65 for all public service schemes.
- <sup>51</sup> The NHS Pensions Scheme is highly valued by members and has been a powerful recruitment and retention tool. An ICM poll of RCN members following the announcement of the consultations indicated that the NHS Pension Scheme was an important reason for joining the NHS and accepting a lower salary during their working career.
- <sup>52</sup> The RCN welcomes many of the proposals for change. The current NHS Pension Scheme dates back to 1948 and reform is needed to make the scheme better fit the needs of a modern nursing workforce. Proposals the RCN welcomes include:
- Improving the way pension is built up (accrual rate) from 1/80<sup>th</sup> to 1/60<sup>th</sup>
  - Giving members more choice over how much lump sum or pension to take
  - Providing survivor benefits to all unmarried partners
  - Flexibility around taking a pension at the end of career (i.e. reducing hours, taking a lower grade job,
  - Introduction of ways to save more for retirement, for example, enhanced pensions for people who work beyond their retirement age and opportunities to build a second pension if people return to work after retirement.
- <sup>53</sup> The UK Government originally stated that the Review was a cost-neutral exercise but is now saying savings must be made. The RCN does not accept that the NHS Pension Scheme has suffered the same degree of problems that funded private sector schemes have or faces the same degree of future risk in respect of poor investment returns and financial deficits.
- <sup>54</sup> The RCN does not believe it is fair that any benefit improvements resulting from the Review can only be financed out of savings produced by an

increase in normal pension age or by increased employee contributions. The UK Government is introducing changes to the pension schemes (e.g. age and civil partnership legislation) that would have to be implemented anyway and but for the Review, would have had to be financed through additional funding.

- <sup>55</sup> RCN members have stated their views on the proposed reform of the NHS pension in unprecedented numbers, by writing letters and emails to the RCN. These views have been confirmed in a representative poll of RCN members conducted by ICM.
- <sup>56</sup> The strength of nursing feeling on this issue was clearly demonstrated at the RCN Congress 2005. Belinda Hodder, a Welsh midwife, submitted an Emergency Resolution which urged the RCN to impress upon Government that industrial action on this issue could not be ruled out. This resolution was overwhelmingly supported, with supporting speeches from many members and ending with a standing ovation for its proposer. Ms Hodder made it clear that the motion was *not* a vote for industrial action but was intended to send a clear message that members would support industrial action if no other avenue was available.

35E Emergency Resolution RCN Congress 2005 - That this meeting of RCN Congress asks Council to impress upon the Government that they will not rule out industrial action over pensions if all other methods fail.

In Favour	441	(95.5%)
Against	18	(3.9%)
Abstain	3	(0.6%)

### **Proposals for a mandatory increase in normal pension age to 65**

- <sup>57</sup> The RCN believes that, because of diversity in individuals capacity and in the increasing demands of nursing roles, an across the board NPA of 65 is inappropriate for nurses.
- <sup>58</sup> The proposal to increase the normal pension age for nurses will, in effect, mean a pay cut. Nurses who are NHS Pension Scheme members who do not reach their normal pension age within the protection period will experience a reduction in their benefits.
- <sup>59</sup> Take, for example, a nurse who currently has 12 years service and is aged 42 years old. If the new scheme had the higher accrual of 1/60th and a normal pension age of 65, even if the member took advantage of protection up to 2013, their pension at age 60 would still be around 9% lower. For a nurse currently on a final salary of £30,247 this means a loss of pension of around £1,050 a year.
- <sup>60</sup> The position is even worse for currently younger staff – in the case of a nurse now aged 32 with 12 years service and a final salary of £30,247 their pension from age 60 would be around £2,090 a year lower.



- <sup>61</sup> A nurse joining the new scheme and retiring at age 60 will generally receive a pension that is around 25% lower than the pension available under the current scheme. For a nurse with 30 years full time equivalent service on a final salary of £30,247 this means a loss in their pension income from retirement of around £3,140 a year.
- <sup>62</sup> A nurse joining the new scheme would need to work around a further 3 years and therefore retire from service at around age 63 to be no worse off in retirement compared to what they could have received had they retired from service at age 60 under the existing scheme. The conclusions are no different if allowance is made for part time working or potential new flexible working arrangements, although the numbers would differ.
- <sup>63</sup> Department of Health research published in 1998 showed that stress levels amongst nurses were 40% higher than in the general population. Indeed, it is more likely that not all nurses will be able to work to 65 and being forced to will create poor health for many. This will lead to an increase in the numbers of ill health retirements and increase the burden on the public purse.
- <sup>64</sup> The ICM poll found that 97% of members opposed a mandatory rise, but it also indicated that members would be willing to work longer if this was not compulsory and employers introduced appropriate support in terms of flexible working, tackling staff shortages, and if the Government and employers addressed violence against healthcare staff

### **Proposals to change to a Career Average Salary Scheme from the current Final Salary scheme**

- <sup>65</sup> Final salary schemes are beneficial for people who experience career progression towards retirement while career average schemes, in theory, are beneficial for those with little or relatively little increase in career earnings.
- <sup>66</sup> The RCN believes that a final salary scheme should be maintained because:
- The new NHS pay system **Agenda For Change** supports greater career progression – it is unhelpful to simultaneously withdraw a pension system which values career progression. Our members view it as the Government giving with one hand and taking away with the other.
  - Career Average schemes are not transparent and are poorly understood. Members will lose the ability to see how career decisions, e.g reducing hours, will impact on final pension entitlement.
  - The final salary scheme is viewed as the gold-standard, is valued by NHS staff and is a powerful recruitment and retention tool.

## **Special Class and Mental Health Officer Protections**

- <sup>67</sup> When the rights to early retirement were withdrawn to new members in 1995 the UK Government promised that existing special class and MHO status had lifetime protection. This was a specific recruitment inducement. Recruitment in these fields remains a problem in Wales and removal of these protections is likely to increase these difficulties
- <sup>68</sup> The RCN believes the Government must honour this promise. This is cost-neutral as these staff would not get any of the proposed scheme improvements which are being paid for out of the rise in NPA.

## **Executive Summary – Section 2**

The RCN:

Opposes a mandatory increase in normal pension age to 65

Believes the Final Salary Scheme should be maintained

Believes the commitment to lifetime protection of special retirement benefits for nurses with special class and MHO status should be honoured

## Section 3 - Agenda for Change (A4C)

- <sup>69</sup> The NHS Whitley system for negotiating pay, terms and conditions has largely been unaltered since its inception in 1948 although there have been some changes. Nevertheless, it has been heavily criticised for decades. These criticisms centred on its structure, complexity, over centralisation, lack of flexibility and equal value.
- <sup>70</sup> Negotiations on a new system began in February 1999 when the four health departments of England, Northern Ireland, Scotland and Wales published the Agenda for Change White Paper.
- <sup>71</sup> Talks came to an end in November 2002, and the Government published a set of proposals in January 2003. After looking closely at the AfC proposals, RCN Council recommended the package to members, on the basis that it would bring significant improvements to nurses' pay, professional development and career opportunities. The RCN was the first trade union involved to ballot its members on the proposals during March and April 2003. The result was resounding "yes", with 88.42% of members who voted, accepting A4C.
- <sup>72</sup> From the very start the RCN Council insisted that any new system must:
- Be a visible improvement
  - Be fair, transparent and UK wide
  - Provide the right rewards to recruit, retain, and operate
  - Be funded appropriately and implemented in a robust way
  - Include a role for the review body
- <sup>73</sup> Before Agenda for Change the NHS had 11 different sets of pay terms and conditions for different groups of staff. This meant a nurse could be doing a job, which required a similar level of knowledge and skills as another NHS staff member, but their pay, terms, and conditions were totally different - the RCN believed this to be unfair.

### Agenda for Change Implementation

- <sup>74</sup> Steady but slow progress is being made in respect of implementing Agenda for Change. However it is clear that a significant number of NHS employers are not going to meet the September 2005 timeline for assimilating staff to the new A4C pay bands. The RCN believes that it is a constructive approach for Welsh Assembly Government to be explicit about these difficulties. This will encourage trust and realistic expectations on all sides.

<b>A4C May update</b>	Matching Process	Assimilation Process
Wales	33%	2%
England	58%	29%
Northern Ireland	32%	Not begun
Scotland	14%	Not begun

The RCN believes the full implementation of Agenda for Change must remain the priority of Government and health agencies.

### **Unsocial Hours Review**

<sup>75</sup> Negotiating a new shift payment system is outstanding business for the NHS across the UK and a priority for RCN Wales. Nursing representatives at a UK level have taken the initiative and presented options for testing to NHS employers in May 2005. Whatever options are selected for testing, the RCN considers pump-priming funding is critical.

<sup>76</sup> Unsocial hours are just that, socially isolating, it is important to value and reward those who nurse in these hours appropriately. Unsocial hours payments are a crucial indicator to the nursing profession of how they are valued, a crucial tool for the employer in incentivising unpopular shifts and ultimately crucial for outcomes in patient care.

The RCN believes that unsocial hours should be rewarded appropriately.

### **The Knowledge and Skills Framework**

<sup>77</sup> The Knowledge and Skills Framework (KSF) is what binds together the Agenda for Change package. It is the Framework of Knowledge and Skills required in any single NHS post. It will be a tool for career development and also for role redefinition. This makes it centrally important, without KSF there will be no cultural change to NHS roles and responsibilities. It is intrinsically linked to benefits realisation. In order for the NHS to be successful in introducing KSF there must be a robust appraisal system already in place.

<sup>78</sup> The issues therefore in its implementation are

- Ensuring appraisal is introduced now in preparation for the KSF which is due to commence in 2006
- Ensuring staff training both for managers and staff
- Funding the required learning needs (including work-based learning) that are identified as a result of the KSF process.

The RCN believes that:

There needs to be ring-fenced funding for the introduction of appraisal, staff training and the required learning needs (this has been done for the medical professions).

Every ward and department should have a learning representative.

## **Impact of A4C on Higher Education**

- <sup>79</sup> Nurse Educators are registered nurses of many years clinical experience who work as lecturers, senior or principal lecturers in higher education. They are nurses who educate the next nursing generation.
- <sup>80</sup> By 1994 nurse educators had been transferred from the NHS to Higher Education (HE). Nurse educators have gradually been assimilated onto university terms and conditions.
- <sup>81</sup> Implementation of Agenda for Change (A4C), the new NHS pay system sets a new challenge. Although the universities have also reached agreement on a new HE Pay Framework. The differential in salary between this HE Pay Framework and A4C is considerable, there is, for example, a gap of £6,000 between the maximum senior lecturer and nurse consultant salaries.
- <sup>82</sup> The higher education pay framework also does not sufficiently acknowledge and reward nursing lecturers' clinical practice as well as their academic profile. As a result promotion prospects for nurse educators within higher education are limited.
- <sup>83</sup> The recruitment of future nurse educators is therefore potentially problematic. This situation is made more pressing by the fact that in the next 10 years 50% of nurse educators are due to retire.
- <sup>84</sup> Without sufficient numbers of nurse educators there will no ability to increase nurse student recruitment and there may be an impact on the ability to maintain current figures.

The RCN believes that the HE sector need to recognise the professional nursing aspects of the nurse educator role and the Pay Framework needs to address this.

## **Impact of A4C on practice nurses and the Independent Sector**

- <sup>85</sup> A4C terms and conditions are not of course mandatory on private employers. This means that practice nurses and nurses working in the independent sector are outside A4C terms and conditions.
- <sup>86</sup> The potential danger of this is that as the considerable benefits of A4C begin to be realised there could be an outflow of nurses from vulnerable sectors such as care homes. The nursing workforce in the independent sector could become professionally compromised by not having access to the opportunities of the Knowledge and Skills Framework. This of course would have an impact on patient care.

<sup>87</sup> In Wales there has been an increase of two-thirds in the number of registered nurses working in GP practices over the period from 1990 to 2002.

**Number WTE practice nurses by country from 1990 to 2002**

	<b>England</b>	<b>Scotland</b>	<b>Wales</b>	<b>GB</b>
<b>1990</b>	7,738	584	418	8,740
<b>1991</b>	8,776	647	524	9,947
<b>1992</b>	9,121	744	519	10,384
<b>1993</b>	9,605	748	552	10,905
<b>1994</b>	9,099	768	582	10,449
<b>1995</b>	9,740	858	622	11,220
<b>1996</b>	9,820	875	637	11,332
<b>1997</b>	10,080	901	642	11,623
<b>1998</b>	10,360	968	665	11,993
<b>1999</b>	10,690	1,003	698	12,391
<b>2000</b>	10,710	1,065	713	12,488
<b>2001</b>	11,160	1,097	738	13,018
<b>2002</b>	11,998	1,181	773	13,954

*Source: Health Statistics Wales, ISD Scotland, and DH*

<sup>88</sup> Nineteen GP practices across Wales have agreed to implement A4C terms and conditions. This is to be welcomed.

<sup>89</sup> Independent care homes are the largest employers of nurses outside the NHS. It is estimated that around 3,200 nurses are working in the independent sector in Wales.

The RCN believes that every effort should be made to encourage the sign-up of independent contractors to the NHS and employers in the independent sector to A4C

## Executive Summary - Section 3 - Agenda for Change

The RCN believes the full implementation of Agenda for Change must remain the priority of Government and health agencies.

The RCN believes that unsocial hours should be rewarded appropriately.

The RCN believes that:

There needs to be ring-fenced funding for the introduction of appraisal, staff training and the required learning needs (this has been done for the medical professions).

Every ward and department should have a learning representative.

The RCN believes that the HE sector need to recognise the professional nursing aspects of the nurse educator role and the Pay Framework needs to address this.

The RCN believes that every effort should be made to encourage the sign-up of independent contractors to the NHS and employers in the independent sector to A4C



## Section 4 - Emergency Care

- <sup>90</sup> On 15th March 2005, a meeting was held at RCN Wales headquarters. The meeting was intended to provide a forum for RCN members to identify solutions to the ongoing Emergency Care problems across Wales.
- <sup>91</sup> Nursing staff and health care professionals alike felt that their workload was unsustainably high and that workplace stress was reaching a dangerous level. As a result staff felt that patient care had been significantly compromised. The participants of the strategic discussion presented a consistent view that many organisational constraints had led to a situation in which nurses and other professionals were often prevented from providing the level of care and treatment they have been trained to give in order to ensure a high quality of service.
- <sup>92</sup> On the 19<sup>th</sup> April the RCN Wales presented the Health and Social Services Minister with a paper containing the recommendations that arose as the result of this meeting. These recommendations contain an emphasis on nursing empowerment as a way to provide solutions.
- <sup>93</sup> RCN Wales is aware of the ongoing work of the Welsh Emergency Care Access Collaborative and looks forward to the imminent publication of **Developing Emergency Care Services** (referred to in the Welsh Assembly Government document **Designed for Life**).
- <sup>94</sup> In this section of our paper we have chosen to emphasise the areas of Emergency Care we feel are most in need of increased scrutiny and where the greatest benefit would result from action.

### Communication between WAG and frontline staff

- <sup>95</sup> RCN Wales found that that the activities of the Welsh Emergency Care Access Collaborative were virtually unknown to frontline staff. All NHS Trusts in Wales are participating as well as NHS Direct and the Welsh Ambulance Trust. Each organisation has appointed a Programme Manager to produce project plans and monthly progress reports. However these Project Managers were unknown to most frontline staff. There was no formalised communication with frontline staff or in most cases with very senior staff. If the implementation of **Developing Emergency Care Services** is to succeed it must learn from the experience of WECAC.

The RCN believes a Communications Strategy between the Welsh Assembly Government and frontline staff must be an integral part of the implementation of **Developing Emergency Care Services**

- <sup>96</sup> There is also the issue of the performance management of Developing Emergency Care Services. Over the last five years England has taken an interventionist route with NHS Trusts with external project teams assisting in the development and implementation of action plans.

## **Consistency of Practice across NHS Trusts – professional policies and procedures**

- <sup>97</sup> Currently nurses who have trained and experienced in a particular skill are unable to continue to use that skill if they transfer to a different NHS Trust in Wales. This is because each Trust currently recognises only its own training programme (although clinically these programmes do not differ).

The RCN believes a national recognition agreement needs to be developed to allow training and competency in certain skills to be recognised across Wales. Such skills would include IV canulation, administration of IV drugs/additives, requesting X ray, administering an anaesthetic, analgesic or antibiotics.

## **Nursing leadership in emergency care**

- <sup>98</sup> There is currently only one approved emergency care nurse consultant post in Wales but this post has not yet been appointed (please note that advanced roles for nurses are discussed in greater depth in Section 5 of this paper). A case history showing the potential role and benefit of an emergency care nurse consultant is contained in the Maxi Nurses brochure that accompanies this paper.
- <sup>99</sup> Northern Ireland has recently developed a national leadership programme specific to emergency care. This development is worth consideration.
- <sup>100</sup> The Medicines and Healthcare Regulatory Authority have just closed a consultation on **Options For The Future Of Independent Prescribing By Extended Formulary Nurse Prescribers** [Reference: MLX 320]. One of the options discussed is to allow nurse prescribers access to the British National Formulary limited by the professional competency of the nurse. The RCN supports this option.

## **Enhance payments (bank) as a specialist field.**

- <sup>101</sup> Areas of work recognised as a specialist field are rewarded by a higher rate of pay. It is an anomaly that although emergency care is recognised as a specialist field it is not classified as one in bank nursing and therefore nurses working a shift for a bank will be paid less. This anomaly should be ended. There should be equal pay for equal levels of responsibility across Wales.

## **Better Co-ordination with, and Access to, Primary Care**

- <sup>102</sup> 'Unscheduled care', 'emergency care' and 'out-of-hours' care are not the same concepts. In most cases patients falling into each of these categories will require a very different kind of service. A patient presenting 'inappropriately' (to use the hospital administration term) in emergency care may face long delays in accessing treatment. The 'out-of-hours'

service co-ordinated by the Local Health Boards is poor in some areas whilst in other areas in Wales there is good practice.

<sup>103</sup> However these traditional categorisations of the health service are increasingly unhelpful. Our lives as nurses and as patients are not '9 to 5 weekdays only'. **Designed for Life** comments:

- a. *Services for people needing emergency treatment or rapid access to social care will be redesigned to create a single contact point so that users are promptly attended to and quickly transferred to the right service when necessary. A network of specialist on-call services will be developed to ensure that emergency patients will be seen by expert clinicians e.g. for vascular surgery. Pre-designed care pathways will ensure that the right treatment in the most appropriate setting from the right person is available as quickly as possible and 24 hours per day. (p.22)*

<sup>104</sup> What Wales needs is more creative solutions utilising a range of healthcare professionals whether nurses, pharmacists and physiotherapists. One such solution is the RCN proposal to develop walk-in centres.

The RCN believes that 'out-of-hours' primary care service needs reviewing at a national level in Wales. Emergency care services, NHS Direct and the local 'out-of-hours' service need to be properly co-ordinated across Wales

### **Co-ordination with the Community**

<sup>105</sup> One of the major pressures on Emergency Care services is the inability of staff to transfer patients into the appropriate ward because these wards in turn lack the ability to discharge patients appropriately. Delayed discharges are not merely an administrative difficulty they represent a less than ideal standard of patient care. More social care staff, intermediate care beds and community nurses are needed to provide the appropriate levels of care in the community.

### **Violence and Abuse of Staff – Zero Tolerance**

<sup>106</sup> The health care workforce is the health service's most precious resource and staff should have the right to carry out their job free from the fear of violence. Unfortunately attacks against staff have become increasingly common throughout the UK. Abuse and violence to NHS staff working in emergency care should not be tolerated.

<sup>107</sup> The RCN is campaigning for a change in the legislation to ensure that all those who commit acts of violence against health care staff are prosecuted. Ensuring the perpetrators are prosecuted will send a powerful message that violence against staff will not be tolerated under any circumstances. Currently the Emergency Workers (Scotland) Act 2005 will increase the penalties faced by those assaulting several named groups of emergency workers, including nurses and midwives.

<sup>108</sup> In an RCN survey 2002, it was reported that following a physical assault no follow up action was taken in nearly 80% of cases. In just 8% of cases, a verbal warning was issued, in 5% care was discontinued and in 5% the incident was reported to the police. In just 2% of cases was an offender prosecuted.

<sup>109</sup> Adequate security measures should be in place in all NHS settings and staff should be supported when incidents occur. Best practice (such as the North Glamorgan NHS Trust 'red card' system) should be rolled out on an All Wales basis.

The RCN believes that Welsh Assembly Government guidance should be issued to NHS Trusts outlining the standards expected to secure the safest possible environment in which to work and the support staff should be able to expect.

<sup>110</sup> In Northern Ireland, a major public campaign was launched by the DHSSPS in 2004 in response to an increasing number of violent incidents against health care staff, particularly in emergency care departments and community settings.

<sup>111</sup> Such a national highly visible campaign in Wales would send a clear message of support to nurses and ensure that potential perpetrators are aware that violence against healthcare staff is not acceptable.

## Executive Summary - Section 4 Emergency Care

The RCN believes a Communications Strategy between the Welsh Assembly Government and frontline staff must be an integral part of the implementation of 'Developing Emergency Care Services'.

The RCN believes a national recognition agreement needs to be developed to allow training and competency in certain skills to be recognised across Wales. Such skills would include IV canulation, administration of IV drugs/additives, requesting X ray, administering an anaesthetic, analgesic or antibiotics.

The RCN believes that 'out-of-hours' primary care service needs reviewing at a national level in Wales. Emergency Care services, NHS Direct and the local 'out-of-hours' service need to be properly co-ordinated across Wales

The RCN believes that Welsh Assembly Government guidance should be issued to NHS Trusts outlining the standards expected to secure the safest possible environment in which to work and the support staff should be able to expect.

## Section 5 - Nurses in Advanced Roles

<sup>112</sup> **Advanced & Specialist Nursing Roles** was a survey published in March 2005. This research had been commissioned by the RCN and the Department of Health. 758 nurses across the UK in advanced-specialist roles were invited to take part in a survey asking them about their jobs – what their role entails, what gives them most satisfaction, and how the role fits in. The response rate of 70% itself demonstrates a key finding – that nurses in these roles feel passionate about their work and are keen to let others know more about what they are doing.

### What is an Advanced Role?

<sup>113</sup> Title and role:

- nurse practitioner (NP),
- clinical nurse specialist (CNS),
- nurse consultant (NC),
- specialist nurse (SN),
- advanced nurse practitioner (ANP).

<sup>114</sup> Whilst the roles have in common the prevalence of key activities such as making professionally autonomous decisions, making referrals and offering specialist advice to other staff the main job titles refer to differences in the activities undertaken by different roles. For example overall CNS and SN undertake a similar range of activities (primarily case management related) and can be regarded as one group. Nurse practitioners see both the 'diagnostic' activity types and 'case management' activities as being what makes them different to other nurses. On the other hand advanced nurse practitioners do more of the diagnostic activities and see these activities as central to their role

<sup>115</sup> Nurse consultants do a wide range of activities but it is the 'diagnostic' and 'organisational' elements of their job that distinguish them from others.

<sup>116</sup> What many advanced and specialist nurses have in common with one another is that they are frequently at the centre of a web of services, practising autonomously to coordinate care. They are part of a number of teams, refer patients from and to several different sources and liaise with other staff (within and beyond health services) to provide expert knowledge and advice.

<sup>117</sup> Respondents typically had between 16 and 20 years nursing experience, 10 years of which was in the specialty they are now based. 96% of respondents were white,

### Nurse Consultants in Wales

<sup>118</sup> Wales' plans to strengthen the career ladder for nurses, midwives and health visitors were outlined in the Strategic Framework for Nursing, Midwifery and Health Visiting: Realising the Potential (NAW 1999). There

are 55 approved consultant nurse (and 3 therapists) posts across Wales. These posts have been approved by Health Professions Wales.

- <sup>119</sup> In Wales the posts are focused upon a generalist approach crucially the approval process (currently a function of HPW) involves establishing the potential benefit to patient care.
- <sup>120</sup> All proposals to establish consultant posts must be developed as a joint submission from a NHS organisation and an institute of higher education. The HPW submission guidelines describe the main functions as being contained within the areas of Expert Practice, Practice and Service development, Leadership and Consultancy, Education, Training and Development and Research and Development.
- <sup>121</sup> These guidelines go on to outline 'Expert Practice' (NOT exclusively) as the consultant to draw "upon advanced knowledge and exercise professional skills of the highest order, to deliver high quality clinical care to patients/clients/communities. This will require the ability to make critical clinical judgements and decision-making in areas where precedents do not exist. 'Practice and Service Development' is outlined (again NOT exclusively) as the consultant to "establish evidence-based protocols for nursing/midwifery care in the area of practice, and contribute to the development of multi-professional standards of care, clinical guidelines and audit, within the field of care provision."
- <sup>122</sup> Despite the 55 approved posts, there are only 23 appointed consultant nurses (of which 5 are midwives). This is very disappointing. Alongside the substantial evidence emerging from England a favourable evaluation of the role of the first 11 nurse consultant posts in Wales has already been undertaken.
- <sup>123</sup> Welsh Assembly Government policy ensures that before any submission for such an advanced post is made, the Chief Executive and the Nursing Director have assessed the financial consequences and support needed for such a role and are assured that this need can be met. Therefore finance should NOT be a reason to delay the appointments process.
- <sup>124</sup> In a few cases there has been a failure to recruit individuals with the requisite skill set. One such case was with 3 posts that had been designated in the field of child and adolescent mental health. However in this case, as with any other, since the need for the establishment of the post *has already been established* at a national level the local agency working with the Welsh Assembly Government should immediately have taken steps to train or otherwise develop nurses to ensure future candidates for such a post.

**Nurse Consultants in England as at September 2004 full time equivalent**

Acute Elderly & General	302
Paediatric	26
Maternity Services	44
Community Psychiatry	24

Other Psychiatry	82
Community Learning Disabilities	13
Other Learning Disabilities	7
Community Services	93
Education Staff	16
School Nursing	0
Unspecified	3
<b>All Areas of Work</b>	<b>609</b>

Source: DoH

The RCN believes that NHS Trusts in Wales should begin the appointment process in the currently approved nurse consultant posts.

### **Nurse prescribing**

<sup>125</sup> There are clear benefits that arise as a consequence of supplementary prescribing. While this activity may reduce pressures on some sectors of the health care workforce, its most important impact is the improved service offered to patients and clients. The patient has improved access to and advice about their medicines and enables more effective use of the skills of pharmacists and nurses. This will enable the more effective development of nurse run clinics.

<sup>126</sup> The five higher education providers for nurse training in Wales and the Welsh School of Pharmacy have worked together to produce an 'All Wales' curriculum. Each centre has been accredited by both Health Professions Wales (on behalf of the Nursing and Midwifery Council, NMC) and the Royal Pharmaceutical Society of Great Britain.

The RCN believes that nurse prescribers should have access to the British National Formulary limited by professional competency

### **Constraints on role development**

<sup>127</sup> The main constraint on role development is simply lack of time. A third of respondents felt that the volume of work meant they were too busy to be able to develop the level of service as they would like. In many cases the posts are unique so post-holders are not able to share their workload with colleagues in order to allow them scope to continue to develop their own role/service in the way they would like.

<sup>128</sup> Outside of increased resourcing, better access to training and professional development and more supervision or mentoring were two of the most frequently suggested forms of support needed. For example, 27% would welcome more clinical support/supervision or mentoring.

<sup>129</sup> These types of post are relatively new, and in some cases the infrastructure and organisational culture has lagged behind the new ways of working, and is not providing the support needed to make the roles as successful as they could be. Lack of understanding of these roles is a potential source of frustration. 23% of those who make referrals, have had



them refused because they are a nurse rather than a doctor. Similarly a third (33%) who order investigations had been refused on the same grounds.

### **Benefits to Patient care**

- <sup>130</sup> Continuity of care, expertise, the provision of information and advice and the ability to build a supportive relationship with patients were frequently cited by nurses in advanced roles as the key advantages of their role to patient care.
- <sup>131</sup> Another major area of benefit identified by respondents, was the accessibility and completeness of the services provided. Patients are able to access the services quickly and because nurses have the authority to act, they are often diagnosed and treated more quickly than would otherwise have been the case, receiving a 'whole package of care' rather than having to be referred on. Patients thus spend less time on a waiting list and in many cases have longer appointments with a health professional with whom they have a relationship of trust.
- <sup>132</sup> Primary Care Nurses in advanced roles can be the key to implementing the principles of the Wanless Report and pushing forward the public health agenda. They can engage in illness prevention activities by supervising clinics, educating communities and running chronic disease management programmes. Primary care nurses are a trusted source of advice to the public and this role should be capitalised on.
- <sup>133</sup> On average nurses in advanced roles express high levels of job satisfaction and are satisfied with their working hours and the level of control they have over their careers. For example, 84% say that most days they feel enthusiastic about their jobs. They are also significantly more likely to feel their work is valued than is reported by survey of a random cross section of RCN members – 62% compared with 54%.

The RCN believes that the Welsh Assembly Government and health agencies should promote nurses in advanced roles and put in place support mechanisms to encourage such development.

## **Executive Summary - Section 5 Advanced Roles for Nurses**

The RCN believes that NHS Trusts in Wales should begin the appointment process in the currently approved nurse consultant posts.

The RCN believes that nurse prescribers should have access to the British National Formulary limited by professional competency.

The RCN believes that the Welsh Assembly Government and health agencies should promote nurses in advanced roles and put in place support mechanisms to encourage such development.

## **Section 6 - Abolition of Health Professions Wales and potential new functions of the National Leadership and Innovations Agency for Healthcare**

- <sup>134</sup> Health Professions Wales was created as an Assembly Sponsored Public Body (ASPB) on the 1 April 2004. The conception of Health Professions Wales was widely consulted on using a change management group for Wales chaired by Vice-Chancellor of Glamorgan and involving the participation of a wide range of professional bodies. This was unanimous in its agreement of the need for an independent ASPB.
- <sup>135</sup> The abolition of Health Professions Wales was announced on the 30th November 2004. It was decided to transfer many of the functions of HPW to the National Leadership and Innovation Agency for Healthcare (NLIAH).
- <sup>136</sup> The establishment of the National Leadership and Innovation Agency for Healthcare had already brought together the functions of: the Innovations in Care Team (IiC) previously based at the Welsh Assembly Government and the Centre for Health Leadership Wales (CHLW).
- <sup>137</sup> It was also decided that some of the functions of the NHS Human Resources Division (HRD) and the finance functions which support them, would also be relocated to a new Workforce Development, Education and Commissioning Unit, (WDEC) to be set up as part of the National Leadership and Innovation Agency for Healthcare (NLIAH).
- <sup>138</sup> NLIAH is “hosted” by Bro Morgannwg NHS Trust. The Chief Executive of Bro Morgannwg Trust is the accountable officer. The performance management of NLIAH is undertaken by the Assembly Government, Performance Management Group, the core functionalities of which are set out in an annual service level agreement, with the NLIAH Chief Executive being accountable to the Head of the Department of Health and Social Care/Chief Executive NHS Wales.

### **Current Role of Health Professions Wales**

- <sup>139</sup> Health Professions Wales (HPW) supports the modernisation and development of the NHS in Wales through ensuring quality education and training for the workforce, including:
- allied health professionals,
  - health care scientists,
  - health visitors,
  - midwives,
  - nurses.
- <sup>140</sup> In addition, HPW:
- Acts as the local supervising authority for midwives
  - Undertakes quality assurance of nursing, midwifery and health visiting courses on behalf of the Nursing and Midwifery Council in Wales
  - Provides an accreditation service for health service personnel

- Awards research training fellowships
- Manages and supports the development of consultant health visitor, midwife, nurse and therapist posts
- Contributes to the future work plan of Skills for Health for the development of the NHS Wales workforce
- Effectively communicates with the UK Regulators (NMC and HPC) to ensure that Welsh issues and requirements are recognised

### **Local Supervisory Authority for Midwives**

<sup>141</sup> HPW is the Local Supervisory Authority for the statutory supervision of midwives in Wales, including preparation, appointing and developing supervisors of midwives. This statutory function is to protect the public and includes the power to suspend midwives from practice. HPW does this by:

- i. Implementing and auditing NMC rules and standards for statutory supervision of midwives throughout Wales, working with Trusts, LHBs and supervisors of midwives;
- ii. Ensuring and enabling the competent practice of midwives through the supervisory network and, where required, investigating allegations of poor midwifery practice.
- iii. Taking appropriate action following investigations into allegations of poor practice, which may include suspension of a midwife from practice or the instigation of a period of supervised practice;

<sup>142</sup> Preparation of supervisors of midwives. As the LSA, HPW contributed to ensuring course provision in Wales, which facilitates preparation and appointment of supervisors of midwives in Wales, to meet NMC minimum ratio standard.

<sup>143</sup> Intention to practise. HPW receives annual intention to practise notification from all midwives practising in Wales and maintaining a database of all practising midwives.

<sup>144</sup> The statutory requirements for the LSA function are contained within The Nursing and Midwifery Order 2001. Upon abolition of HPW the LSA function will be exercisable by the Welsh Assembly Government. Although this did occur previously for a short time before the formation of Health Professions Wales this was only accepted by the profession and by the regulatory body the Nursing and Midwifery Council as an interim measure. It is an inherently problematic arrangement. For example independently employed midwives would effectively be directly answerable to the Minister for Health and Social Services. Decisions on suspension or appeals would then lose or appear to have lost both the professional lead and political independence.

The functions of the Local Supervisory Authority for Midwives should be exercised by a body seen to be independent in operation of the Welsh Assembly Government.

## Quality Assurance

- <sup>145</sup> Public protection demands that the highest standards for education and training are set and maintained in the process of professional accreditation.
- <sup>146</sup> HPW also delivers the Nursing and Midwifery Council (NMC) UK-wide QA framework, within the context of Wales, assuring and enhancing the quality of both practice and campus-based learning across all programmes which lead to post registration recording on the Professional Register in fields such as intensive care or palliative care.
- <sup>147</sup> Quality assurance activity includes institutional approval; programme approval, modification, re-approval and endorsement. This function is provided via a Service Level Agreement (SLA) on behalf of the NMC, which terminates 31st March 2006.
- <sup>148</sup> HPW also provide a joint accreditation function with HEIs for a Nursing, Midwifery and Health Visiting Continuing Professional Development Framework.
- <sup>149</sup> Fitness for practice. HPW enabled the co-ordinated introduction of the new pre-registration nursing and midwifery fitness for practice standards across Wales, thus streamlining the process considerably. This involved working with the Welsh Assembly Government and HEI's to develop and approve nine core elements of the fitness for practice curricula. The ongoing benefit is that any changes are subject to a single re-approval for the five education providers in Wales and common principles apply across all educational establishments.
- <sup>150</sup> It is important to ensure that the abolition of Health Professions Wales does not lead to a situation where different courses in the same field are offered by different health agencies in Wales leading to a confusing situation that would prevent the transfer of skilled and qualified nurses. One helpful example that might show the way forward is the All Wales Prescribing Initiative that has established accountable officers and provides a curriculum that is approved across Wales.
- <sup>151</sup> The intention to make NLIAH responsible for both the commissioning of education and the quality assurance process is of serious concern to RCN Wales. The quality assurance process needs to be maintained separate and independent of the commissioning process for education.

The RCN believes the quality assurance process for post-registration qualifications needs to be maintained separate and independent of the commissioning process for education.

## **Workforce Development Education and Commissioning Unit**

<sup>152</sup> The commissioning of education and training for nursing and the allied health professionals must be accorded a high priority. The current proposals for the Workforce Development Education and Commissioning Unit that will function as part of NLIAH are therefore of considerable interest. It is important that the National Assembly for Wales retains the ability to scrutinise this unit while democratic accountability for policy unambiguously remains with the Welsh Assembly Government.

<sup>153</sup> Similarly there needs to be a professional lead for nursing within the leadership development programme. Policy advice (as distinct to operational leadership) would of course continue to emanate from the Office of the Chief Nursing Officer.

The RCN believes that there should be a professional nursing lead within the leadership development programme and within the Workforce Development Education and Commissioning Unit.

## **The NHS Student Bursary Scheme: Student Awards Unit function**

<sup>154</sup> HPW also currently implements the NHS Wales Bursary Schemes which provides funding for healthcare students on NHS funded courses in Wales and Welsh domiciled medical and dental students within the UK. HPW does this by:

- iv. Assessing, on an annual basis, bursary holders entitlement to bursary and other allowances, for example, disabled student allowances;
- v. Arranging payment of tuition fees and travel expenses for medical and dental students;
- vi. Assessing quarterly, entitlement to childcare allowances;
- vii. Supporting and advising the Welsh Assembly Government in determining policy on student bursaries.

<sup>155</sup> As part of the change programme of establishing the WDEC Unit, Project Board agreed that this function be transferred to Bro Morgannwg Trust using a Section 41 Agreement under the Government of Wales Act 1998, to be undertaken by NLIAH.

<sup>156</sup> RCN Wales is concerned that given the importance of the financial support this unit delivers to nursing students that there should be a seamless transition of these functions to any new organisation. In particular any new location of the unit must be at least as geographically easy for nursing students to access. Moreover every effort should be made to retain the skills and knowledge base of the current employees.

## **Executive Summary Section 6 - Abolition of Health Profession Wales and transfer of functions to National Leadership Innovations Agency for Healthcare**

The functions of the Local Supervisory Authority for Midwives should be exercised by a body seen to be independent in operation of the Welsh Assembly Government.

The RCN believes the quality assurance process for post-registration qualifications needs to be maintained separate and independent of the commissioning process for education.

The RCN believes that there should be a professional nursing lead within the leadership development programme and within the Workforce Development Education and Commissioning Unit.

## Appendix 1

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[www.hpw.org.uk](http://www.hpw.org.uk)

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# Maxi nurses:

nurses working in advanced and extended roles  
promoting and developing patient-centred health care



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This document complements the Survey of RCN members in advanced and specialist nursing roles, which was commissioned by the RCN and the Department of Health, England. The research was carried out by Jane Ball of Employment Research Ltd. For further information e-mail [info@employmentresearch.co.uk](mailto:info@employmentresearch.co.uk)

A copy of the full survey results can be found on the RCN website and downloadable as a PDF from [www.rcn.org.uk](http://www.rcn.org.uk)

## Foreword

The Royal College of Nursing (RCN) and the Chief Nursing Officers for England, Scotland, Wales and Northern Ireland are delighted to present the findings from the largest study to date of nurses working in advanced and specialist nursing roles across the UK.

Over recent years a wide range of new and extended nursing roles have developed. However, there have been some suggestions that this has meant that core nursing skills have been lost, or that nursing care has been delegated to others. This report clearly highlights that nurses working in these roles see themselves as *maxi nurses* not *mini doctors*, and 98% report that nursing skills are essential to the job they do on a daily basis.

These nurses are at the centre of a web of services co-ordinating packages of care, working across organisational boundaries and leading multidisciplinary teams. They provide expert knowledge and advice however it is patient contact and the ability to travel with the patient from the beginning to end of their health care journey that contributes to both high levels of job satisfaction and a positive impact on patient care.

These roles also create important career development opportunities that will be invaluable in retaining experienced nurses in the future.

It is clear that these nurses are at the leading edge of transforming how health services are delivered, and that their nursing skills, knowledge and experience are central to achieving this. Growing and nurturing these roles is therefore be critical to the continued development of patient-centred health services across the UK.

**Dr Beverly Malone RN PhD FAAN**  
RCN General Secretary

**Chris Beasley**  
Chief Nursing Officer, England

## Introduction

The RCN and the Department of Health have jointly funded the largest survey of its kind to find out more about nurses working in advanced and extended roles, and how proactive they are in developing the roles and services.

The 758 nurses were asked about what their role entails, what gives them most satisfaction, and how their job fits in with other nursing roles. Nearly 70% returned completed questionnaires. The response rate demonstrates just how passionate these nurses are about their work, and how keen they are to let others know more about what they are doing.

### Inspiring

To complete the picture revealed in the findings of the main survey (see below for details of how to get a copy), we decided to look in detail at a number of inspiring nurses from across the UK.

In the following section, all nine nurses featured in the case studies are pushing forward the boundaries of nursing. They describe in their own words what they do, why they are excited about their jobs and the impact they are having on patient care.

### Survey results

The survey results highlight how the nurses carrying out these roles have huge potential to contribute positively to service delivery and the quality of patient care. However, it also reveals that time and funding constraints are holding some nurses back. They are in unique posts and there is simply not enough time or colleague support to get the job done. Getting suitable training to develop services further is also an issue. And because these types of post are new, the infrastructure and organisational culture in many trusts is lagging behind new approaches to service delivery.

Key findings from the survey reveal:

- a nursing background is essential to undertake these roles, they are *maxi nurses* not *mini doctors*
- nurses are very positive about these new roles and are keen for further role expansion
- nurses are leading multidisciplinary teams, working across organisational boundaries and co-ordinating packages of care
- the roles are having a positive impact on patient care, and levels of job satisfaction are high among post holders
- the roles create important career development opportunities that allow nurses to retain significant patient contact.

Copies of the full report *Survey of RCN members in advanced and specialist nursing roles* is available as a free download from the RCN website [www.rcn.org.uk](http://www.rcn.org.uk)

## Pushing forward the boundaries of nursing: a series of case studies

<b>Name:</b>	Elizabeth Wood
<b>Job title:</b>	Clinical nurse educator
<b>Field of practice:</b>	Primary care/community
<b>Setting:</b>	Walk-in centre
<b>Employer:</b>	Loughborough NHS Walk-in Centre
<b>Country/county:</b>	Loughborough/Leicestershire
<b>Date came into post:</b>	January 2003
<b>Previous job:</b>	Nurse adviser
<b>Qualifications:</b>	RGN

### Liz Wood

I used to work as a community nurse, and then I applied for a post as a nurse adviser at the Walk-in Centre in July 2001. I'd heard of this new initiative and I was interested but didn't know anything much about it. The learning curve was massive and my role completely turned around. I had moved into different areas and was making different decisions. I took a course in illness to equip me to do the job, and then a course in injuries to become suitably qualified.

I love my job and travel 50 miles a day to get here (often taking an hour each way) where as my in previous job worked in my own village. But it's well worth the journey.

I work autonomously, but there is GP on the premises who acts as a resource to be used by nurses. Initially the change in role was quite a shock. I had a variety of experience (acute medical

wards, gastro-enterology, and cardiology) but I had always worked in a traditional role. This was quite different. I found that I was using skills I had, but didn't really know I'd got, because I had not had the opportunity to put them into practice before. These roles really do give nurses permission to liberate their talents, it's wonderful.

A good number of people come here and the unit has a really good reputation in the area, so we often have a very full waiting room. It's the first port of call for many people. There are no appointments, and it's run on a walk-in principle. It operates 24 hours-a-day, 365 days-a-year. You literally don't know what's coming through the door next. We've got the facilities we need on site so for example we can take an X-ray, interpret it and plaster straight away. Similarly we can deal with acute medical conditions, for example starting antibiotics for a chest infection as necessary. We deal with any acute problems. If someone has a chronic condition then we are not the most suitable service – we give one-off advice but our aim is to refer them to more appropriate care.

I enjoy having the confidence to practice at this level and believing in what I'm doing. I still see my nursing skills as very important. It's the knowledge I've acquired as a nurse that has put me in this position. You only realise the amount of knowledge you have taken on board when you start in a role like this. I've learnt a lot more than I realised but in traditional roles you don't have the scope to use it to the full. I always had to have permission to use that knowledge before. Now it's very liberating and we all learn from one another within the team and share information all the time. There isn't a blame culture so we can learn from problems and support each other.

My advice to anyone thinking of getting into a role like this is to do a variety of other jobs. You need as much experience and knowledge as you can from other roles. Variety is important as it gives you that background knowledge. You also need to do the appropriate courses. The most important thing is being interested and having the confidence to just go for it. There's a certain breed of nurses that enjoy this role – but it's not for everyone. But if it appeals to you, that's what you need – enthusiasm for it – and that enthusiasm grows once you're the post.

A lot of nurses know their knowledge is good, and this is an ideal opportunity to use that knowledge and continue to learn. If you enjoy learning this is the ideal place to be. It's dynamic, the whole department is – it's evolved since the day it opened and it's still evolving.

People say the NHS is in trouble and not changing but I don't know where they are looking. I've seen so many positive changes and developments. There are so many developments and they don't just benefit patients but also offer a lot of opportunities for staff.

The opportunities are there. But you have to believe in yourself. Believe you can do it – I would never have thought I could do a Masters course. But you can. People under-estimate their own abilities, but once they get started they discover they can do it.

*“The opportunities are there. But you have to believe in yourself. Believe you can do it – I would never have thought I could do a Masters course. But you can. People underestimate their own abilities, but once they get started they discover they can do it.”*



<b>Name:</b>	Penny Keith
<b>Job title:</b>	Nurse practitioner
<b>Field of practice:</b>	Primary care/community
<b>Setting:</b>	PMS project – nurse-led
<b>Employer:</b>	Meadowell Centre
<b>Country/county:</b>	Watford, Hertfordshire
<b>Date came into post:</b>	February 2003
<b>Previous job:</b>	Nurse practitioner – GP practice
<b>Qualifications:</b>	BA, BSc, RGN, DN

## Penny Keith

I have two jobs. I spend three days-a-week at Meadowwell centre as a nurse practitioner, and two days at South Bank University. I provide a nurse-led GMS service for homeless people (about 400 on the books), trying to offer a proactive service, but actually a lot is reactive. It's funded by the PCT, but with support funding from the Department of Health.

I was involved from the outset - in the design of building, appointing staff, deciding which services to offer and how to deliver them. I took up the post two years ago, and the centre opened to patients a year ago. The first year was spent planning/building.

Before I came to Watford I had been working in a GP practice in Walthamstow, with lot of disadvantaged groups. When I moved I was looking for something different – I didn't want to be mainstream. In this job I feel I'm at the cutting edge again, and it's definitely what I want to be doing. I wanted to advance my skills that bit further but still be able to stay in the area. I

now feel I am using the skills I have and have developed them further and can really see how these skills benefit patients.

A lot of the job is about building up relationships with people and harm minimisation. For example, we run a hep B programme and also do cervical cytology. Many homeless people have not had a smear for 10 years if at all. To get the services off the ground means building up trust, so that people feel able to talk about their health needs.

Much of the work involves co-ordinating the services that people receive. I do a new patient appointment, checking against criteria to assess which pathway they should follow. I link in with other services, for example the GP has a specialist interest in substance misuse.

People don't generally understand the role. They're familiar with the idea of a practice nurses but don't have experience of nurse practitioners. Part of my job has been to try and explain the role to other people – not just to patients but telling other agencies, local groups, voluntary organisations and local schools about the service. It involves getting your face known.

I love this way of working. I have an autonomous practice utilising my skills to the full and managing the patient care that I'm offering, but also linking them in with services that they need from elsewhere. It can be isolating being the only nurse and also time is very precious and pressured. There is always suspicion about a new role, but my time at South Bank is a good counterbalance. It allows me to keep links with other people, and I'm now doing my Masters.

It's very much a nursing role, which is ideal for me as I wanted to stay in nursing but develop myself. I had been working at a walk-in centre, and might have stayed there, but didn't feel it was where I really wanted to be. I really enjoy the level of autonomy.

*“It's very much a nursing role, which is ideal for me as I wanted to stay in nursing but develop myself.”*

<b>Name:</b>	<b>Avril Clarke</b>
<b>Job title:</b>	<b>Senior sister</b>
<b>Field of practice:</b>	<b>Occupational health</b>
<b>Setting:</b>	<b>Hospital/industry</b>
<b>Employer:</b>	<b>South Tees Hospitals NHS Trust</b>
<b>Country/county:</b>	<b>Middlesborough, Cleveland</b>
<b>Date came into post:</b>	<b>January 1985</b>
<b>Previous job:</b>	<b>District nurse</b>
<b>Qualifications:</b>	<b>RGN, SCM, OHNC, Cert Counselling, Cert Travel Medicine, HIV 934</b>

## Avril Clarke

I work in occupational health. I'm employed by an NHS trust and provide a service for all the staff on the hospital site which is between 7,000 to 8,000 people. Not all are employees of the trust (some are with different contractors), but we provide an occupational health service for everyone. We also provide a service to the school of health employees and student nurses and other health study students (approximately 1,000 per year).

I first trained in occupational health in 1971. I had been working with British Steel but was rehabilitated into occupational health after a serious injury. Before then I had done district nursing, terminal care, and midwifery, and I use all of that experience in my current job.

Occupational health is about controlling the healthiness of the environment that staff and patients are in. It's a two-way thing – protecting staff from patients and vice versa. Occupational health gets involved in any outbreaks (for example, diarrhoea

and MRSA), taking samples and a history to minimise spread of infection. We provide vaccinations, such as hep B for junior doctors joining every February and August. We do full blood profiles on staff and TB skin tests and X-rays. We check everyone has immunity against measles and chicken pox, and it's more cost-effective to get everyone up to date than risk having an outbreak.

The service also income-generates for the trust as we provide a service for local companies. You deal with lot of different people in this job, from consultants to dustmen. We are able to give advice in a confidential and low-key way.

The job allows me to practise as a senior nurse but still be able to stay hands on and do what I was trained to do. I enjoy the variety in the job.

My advice to others interested in this sort of work is to get hands on experience of a variety of illnesses and situations. A&E is a useful background for occupational health. You need to have the ability to deal with people who are not easy to deal with – health staff themselves.

I have worked in ITU, and have seen the end result of carelessness in the workplace. It's good to be able see the impact of avoiding problems and minimising risk. We are the first port of call for a lot of people and if we cannot help then we can usually redirect them to other services. You need to have the ability to access information. Local groups, journals and universities are good sources of support.

*“The job allows me to practise as a senior nurse but still be able to stay hands on and do what I was trained to do. I enjoy the variety in the job.”*



<b>Name:</b>	<b>Bernadette Griffin</b>
<b>Job title:</b>	<b>Cancer information nurse specialist</b>
<b>Field of practice:</b>	<b>Oncology/palliative care</b>
<b>Setting:</b>	<b>Helpline/education</b>
<b>Employer:</b>	<b>CancerBACUP (charity)</b>
<b>Country/county:</b>	<b>London</b>
<b>Date came into post:</b>	<b>May 2000</b>
<b>Previous job:</b>	<b>Team leader – hospice ward</b>
<b>Qualifications:</b>	<b>RN, DipHE (palliative care), Oncology Nursing Certificate</b>

## Bernadette Griffin

I work on a telephone helpline providing information and support to people affected by cancer. Part of my job is shift-work: I spend four hours on the helpline per day, dealing with between 12 to 16 enquiries per shift. It's very varied. One of the things I really like is that people can ring at a time that suits them and we can give them as much time as they need. Phone calls can sometimes last for up to an hour. There are not that many jobs in nursing where you can set aside time for individuals without fear of interruption.

Outside of my telephone time I also deal with email enquiries (we have up to 250 per month) and some of these can be as complex as our calls. Some involve doing research before you can answer the enquiry, so it's very interesting. I love oncology and have learnt so much through the job and feel that I am

learning all the time. We have a regular weekly journal club where we take it in turns to review articles and feed back to the rest of the team. It helps us to keep up-to-date with new treatments and the results of clinical trials. Once a fortnight we have a consultant or CNS coming to do talks or teaching sessions. We also have the opportunity to go to national and international conferences.

What first attracted me to the job was the informal style of patient education, as I was interested in teaching. I also co-ordinate external talks about our service. For instance, the other evening we gave a talk to a group of deaf people. CancerBACUP does a lot of outreach work and is constantly looking at ways of developing our service and information to reach groups who are disadvantaged either by language or disability. I strongly endorse this aspect of our organisation's work.

Sometimes I speak to people, who are clearly very distressed, but I feel that by giving them information and time and listening to them, I'm making a difference. You can hear the relief in their voices, to have unburdened themselves and got some reassurance. Because it's a confidential helpline people can ask the difficult questions and can be more honest about their fears or needs than they can be with people they have an on-going relationship with – whether that's friends, family or other health professionals.

I definitely see this as a nursing role. I'm a nurse specialising in information giving and emotional support. I really feel that I'm using my oncology and palliative nursing experience in this job to help people. It would be quite a difficult job to do without oncology nursing experience and cancer nursing qualifications. Both are essential to doing this job.

*“I definitely see this as a nursing role. I'm a nurse specialising in information giving and emotional support. I really feel that I'm using my oncology and palliative nursing experience in this job to help people.”*





<b>Name:</b>	Mark Nicholls
<b>Job title:</b>	Lead nurse/manager haemodialysis
<b>Field of practice:</b>	Renal
<b>Setting:</b>	NHS hospital and satellite units
<b>Employer:</b>	East Kent Hospitals NHS Trust
<b>Country/county:</b>	Kent
<b>Date came into post:</b>	Feb 2000
<b>Previous job:</b>	Ward manager
<b>Qualifications:</b>	RGN, ENB 998

## Mark Nicholls

I'm the lead nurse for haemodialysis. The role is a combination of lead nurse, clinical nurse specialist, and a matron role. I facilitate haemodialysis across east and a large part of west Kent. I co-ordinate the service delivered by the central unit and three satellite units, which involves a total of 63 staff.

I started my career as a nursing auxiliary (in 1977) in this same health authority. I've been working in renal since 1982 when I was a newly qualified staff nurse. I feel I've grown with the trust. When I started as a dialysis nurse we would dialyse about 20 patients in a week. Now we do more than that in a morning. The service has expanded and changed. I feel that I can take some pride in that – I hope I contributed a bit to that. I work in what is a now a large ambitious department with a small company culture. Everyone believes passionately about making a difference for the patients. There's a lot of autonomy as a facilitator, but I work very closely in what is a close

multidisciplinary team – dieticians, social workers, counsellors, specialist nurses, therapists, consultants, business managers, doctors and others. It's a diverse mix of people, but all working with a common aim.

The role is challenging, as you've got to balance a lot of different elements: people management; budgetary control; clinical work; and developing staff clinically. I'm also heavily involved in the future development of the service in terms of facilities, and the staff and myself have strong educational links with the local university college, where I am a visiting lecturer.

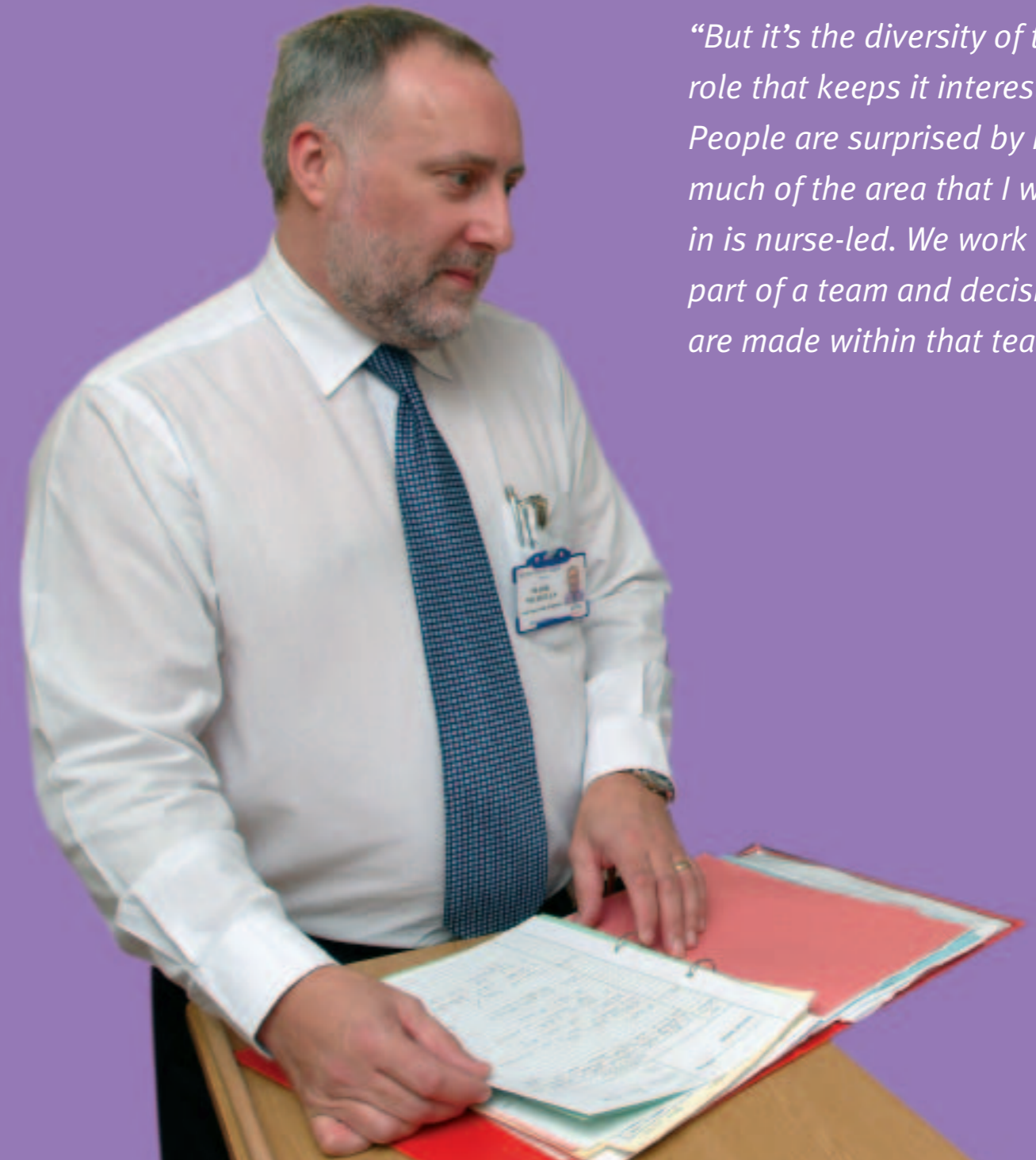
The mix within the role is changing, but nursing skills are still important. I need to be able to assess and manage priorities. Communication skills are particularly important. Not just with patients but with the multidisciplinary team too. An increasing number of patients are having haemodialysis, and it doesn't matter how much machinery you have, patients still need thorough assessment and observation. There are many psycho-social aspects to the care as well – this is a life-long problem for some people.

But it's the diversity of the role that keeps it interesting. People are surprised by how much of the area that I work in is nurse-led. We work as part of a team and decisions are made within that team.

Ultimately we aim to make sure that patients with chronic renal disease can receive the service they need in a timely manner when they need it, and that if they have problems we can help them to get out of trouble. It's a very responsive service – both in terms of reacting to patient clinical needs and adapting to service needs as well.

My advice to anyone interested in getting into this sort of role is to achieve a good all round general experience, and then find the specialty you enjoy most and feel you can do your best at.

*“But it's the diversity of the role that keeps it interesting. People are surprised by how much of the area that I work in is nurse-led. We work as part of a team and decisions are made within that team.”*



<b>Name:</b>	<b>Christine Finlay</b>
<b>Job title:</b>	<b>Colorectal nurse</b>
<b>Field of practice:</b>	<b>Colorectal</b>
<b>Setting:</b>	<b>NHS hospital and community</b>
<b>Employer:</b>	<b>NHS Grampian</b>
<b>Country/county:</b>	<b>Scotland</b>
<b>Date came into post:</b>	<b>January 1996</b>
<b>Previous job:</b>	<b>Staff nurse</b>
<b>Qualifications:</b>	<b>RSCN, RGN, ENB216, ENB980</b>

## Christine Finlay

I've been in this job for nine years now, and really enjoy having the opportunity to see colorectal patients all the way through from community, clinics, hospital, and back in the community. I work three days a week in hospital and two days a week in the community. We run nurse-led clinics to see surgical patients, and offer fistula management. We take referrals from anyone, and patients can refer themselves back to the service.

This role allows continuity of care. You have an ongoing relationship with patients from the first time you meet them. Because I see patients in both the hospital and the community, I can make sure they have a smooth transition between the two. I liaise with hospital staff and community staff to make sure they know what the patients have been going through.

Also the role is flexible. I know what needs to be done and have the freedom to get on and do it. We're not restricted so we are able to develop the service to meet patients' needs and improve care, which is what we've done recently. We're now running

clinics for patients with internal pouches. A big part of the role is explaining what's involved with all options. We put people in touch with other patients so that they can be sure in their own mind that they have made the right decision for themselves.

I used to be a senior staff nurse on a colorectal ward, but for me it was getting to the stage that, as a nurse in charge, I was spending time co-ordinating other people's input. There seemed to be little opportunity for me to be focused on delivering care myself. My role now gives me the buzz of hands-on care and seeing patients all the way through. I plan their care and organise everything that's needed from prescriptions, to organising appointments or discussing problems that patients are having with consultants. And I'm no longer governed by ward-rounds. It's very much about doing things as you feel you need to, there and then, no waiting. Patients come to expect it and they appreciate it.

The service is accessible to the patients. They can pick up the phone and have a chat, and we have the time to delve a bit deeper than other professionals can, which means we can iron out a few more problems. Because you have expert knowledge you can advise GPs about suitable products or treatments. I can act as an intermediary between patients and GPs, which can save patients (and their GPs) time, and prevent a lot of unnecessary hospital admissions.

When new surgical techniques are introduced I go into theatre. That way I have a better insight into what is required, and what's going on behind the scenes. We work closely with consultants so we can understand and anticipate what patients need - almost a step ahead - and that means we can give patients good advice. We also act as the patients' advocate.

Stoma nurses don't just change the bags. There's so much more to it. You feel you've achieved something at the end of every day. You've reassured someone preoperatively, and when you go back and see them a couple of days later they say: "Everything

happened exactly as you said it would." Then you think perhaps maybe you do know something! Some people will refer to you as an expert, but we are not used to thinking of ourselves in that way! We realise we do have a lot of knowledge and experience and we are a resource. This is not just for patients but for surgeons, GPs, nurses and all health care workers, by offering advice or teaching both formally and informally.

*"I know what needs to be done and have the freedom to get on and do it."*



<b>Name:</b>	<b>Garrett Martin</b>
<b>Job title:</b>	<b>Nurse consultant</b>
<b>Field of practice:</b>	<b>Emergency care</b>
<b>Setting:</b>	<b>NHS hospital unit</b>
<b>Employer:</b>	<b>Altnagelvin Area Hospital</b>
<b>Country/county:</b>	<b>Londonderry, Northern Ireland</b>
<b>Date came into post:</b>	<b>November 2001</b>
<b>Previous job: development</b>	<b>Senior nurse practice</b>
<b>Qualifications:</b>	<b>BSC (Hons), Post Grad Cert x 2, RGN, RMN</b>

## Garrett Martin

I'm a nurse consultant based in the A&E department, which has a remit across two trusts and three A&E departments. But increasingly, the emergency care role is wider than what happens within an A&E department.

The nice things about the job are having the autonomy and freedom to work across the organisation and across groups, and across different communities to a degree as well. The nurse consultant role is in its infancy, but it has a wide remit. This can be seen as negative (in term of workloads), but it's very liberating in many ways. A big part of the role is practice development and service development.

Nurses play a unique role in emergency care. The technical skills are important, but they are not the only important aspect. It's about developing patient care services overall, which sometimes means challenging departments about the ways we work to ensure that we provide better experiences for patients.

My job is absolutely about nursing. Of course, in clinical practice some of the activities you do may have previously been in the realm of medical practice. But the care that is delivered is patient care not medical or nursing care. If you can do the activities competently then you should do it. It's not about replacing doctors with highly skilled nurses, but about giving patients the treatment they need.

The role is also about developing others to be able to deliver care. The impact of my role would be very small if it was just me. Part of my job involves breaking down myths about 'patients must see a doctor' or 'a doctor must request X-rays'.

Some of that development means challenging our own profession to think about the essence and fundamentals of patient care. Providing leadership to challenge the way we think about things and helping others to develop the skills, knowledge and expertise they need.

For instance, when I took up the post there were no nurse referrals to X-ray. A lot of barriers were put in place, both from nurses and from other professions. But over six months the barriers gradually broke down. The legal barrier was a myth. We piloted nurse referrals first, did a little training and checked competencies, and then we evaluated the pilot. It showed not only that it was possible, but that nurses are often able to refer more appropriately than junior medical staff. X-ray staff now like nurse referrals because of the quality of the clinical histories. Now 50% of staff on all three sites can refer to X-ray.

We now have eight nurse practitioner roles. We had to be able to demonstrate the benefit of nurse practitioners, for example, the reduction on waiting times. Some staff practice to a very high level seeing 40% to 50% of attendances. They have the support of their medical colleagues. Now patients are coming in asking to see nurse practitioners. Ordinary emergency care staff nurses with 10 years' experience can competently assess and dress wounds without requiring a junior doctor's

assessment. In the past a doctor would look at it and say: "It needs dressing by the nurse." It means moving away from dependency, and having the confidence and the autonomy to take responsibility to deliver better patient care.

I feel I am a conduit between strategic policy developers and practice. That was something nurses felt aggrieved about: "Who were the faceless people developing policies and services?" Now practice is really starting to inform policy. Important policy can be implemented better, more quickly and smoothly on the shop floor. I have a link with people who have influence at strategic and political level. Demonstrating the value of the nurse consultant role, I work at all those different levels – individual, organisational, and strategic/political. The role is very exciting!

*"Some of that development means challenging our own profession to think about the essence and fundamentals of patient care."*



<b>Name:</b>	Daxa Vaidya
<b>Job title:</b>	Nurse practitioner
<b>Field of practice:</b>	Primary care/community
<b>Setting:</b>	GP practice
<b>Employer:</b>	
<b>Country/county:</b>	Leicester
<b>Date came into post:</b>	May 2001
<b>Previous job:</b>	Practice nurse
<b>Qualifications:</b>	RGN, BSc (Hons) Specialist Practitioner, PG Cert in Advanced Nurse Assessment & Diagnostic Reasoning, MSc Diagnostic Reasoning, Extended and Supplementary Nurse Prescribing

## Daxa Vaidya

I work as a nurse practitioner with a GP practice in the inner city. My range of duties varies and includes all the general practice nursing such as cervical cytology and travel health, to chronic disease management and opportunistic screening. The extended duties include triage, emergency treatments or dealing or treating those patients requesting same-day appointments. This includes any walking and wounded, rashes and requests for general health advice on pyrexia and tummy upsets. The surgery aims to meet the DH targets for seeing a health care professional within 24 hours and the GP in 48 hours.

On completing my BSc in Practice Nursing, the natural progression was to use the knowledge and increase my role within the practice. My previous employer was not keen for this, so when I saw this job advertised, I took the opportunity and applied. My present employer was looking for a nurse to expand her role and to share his workload. To perform the extended role, I had to undertake the PG Cert at Derby University. The course was an in-depth study of the pathophysiology of disease, assessment and management of the condition. It also formed a framework for developing knowledge and understanding of the extended nurse role in the context of an independent practitioner.

It's the variety of the job I enjoy, and you know that you can make a difference at the time of the crisis in the patient's mind. For example, recently a young boy attended with a flare of his eczema. I assessed him and commenced treatment and asked him to return a week later for a review/reassessment. The transformation was excellent. The first time he came in, he was wearing a long sleeved top with collars pulled up and a cap to cover his face. On his second visit, he was wearing a T-shirt and no cap, and you could see the confidence return. With the teenagers, self-image is important and commencing treatment at the time of presentation is very important.

My advice to anyone thinking about extending their role is go for it. It gives you job satisfaction, and allows you to complete the episode of care. After all, in many cases, it is the nurse assessing and initiating treatment. You do need a good range of nursing experience, the support of your work colleagues and the most important of all, is the support of your GP employer. I have found that now that I work in my extended role, my GP and I work more closely together, he supports me well. Links with other nurses from the course, and working in the extended role are also very supportive.

*“My advice to anyone thinking about extending their role is go for it. It gives you job satisfaction, and allows you to complete the episode of care. After all, in many cases, it is the nurse assessing and initiating treatment.”*



<b>Name:</b>	<b>Dorlinda Pooley</b>
<b>Job title:</b>	<b>Clinical nurse specialist</b>
<b>Field of practice:</b>	<b>Cystic fibrosis and nutrition</b>
<b>Setting:</b>	<b>NHS hospital unit, community and POPD</b>
<b>Employer:</b>	<b>Singleton Hospital</b>
<b>Country/county:</b>	<b>Wales</b>
<b>Date came into post:</b>	<b>July 1998</b>
<b>Previous job:</b>	<b>Ward manager</b>
<b>Qualifications:</b>	<b>RGN, RSCN</b>

## Dorinda Pooley

I qualified from general nursing in 1966, then as a children's nurse in 1985. I'd been working with children all through my career but wanted to have the appropriate training to take it further. I had a sister post at Morrision Hospital, and then at Singleton Hospital I was senior sister. About five or six years ago I thought I was ready to retire. But the senior nurses heard about it and didn't want me to go! I was invited to take up a new specialist post for children with cystic fibrosis (CF).

Being a specialist nurse you're giving back a lot to your children and their parents – you almost become an extended part of the family. I've never had so many Christmas presents as I have since I've been doing this job! Parents really value you. You're there to support them through the good and bad days. I like working on a one-to-one basis and having close contact with families. I know that I'm valued and I value my patients.

I work within a team. We all work together but each of us has a different role and one person couldn't do another's role. You have to pull together to give good service to patients.

I'm learning new things about children with CF and about gastroenterology (GE) all the time. But I also have the opportunity to pass on the skills and experience that I have by teaching newly qualified staff. They are keen to be able to learn from people with experience – not just from books.

I get a lot of study time – to go to CF conferences and GE conferences. It's important to network. It helps to build confidence in the service you are delivering when you can see similar developments happening elsewhere.

As a specialist nurse you have to really enjoy your work, and then you can give 100%. As well as my work in the hospital I visit the children at home, and also visit schools to liaise with teachers and explain to them about children's conditions. I get asked to talk about the conditions – raising public awareness. I have good contacts with charities and have managed to get quite a lot of children to have their wish, such as a trip to Euro Disney, or meeting the Liverpool football team. It enriches the quality of life.

I've also got a good understanding of the disability living allowance – to make sure that I can help parents. It's not just the clinical side I love but I feel I'm here to fight their corner. I'm at the end of telephone if they need me, and if they feel desperate, they know they can ring me at home. That's what's really important – making sure there's a named nurse there that the children, and their parents, feel they can trust.

*“It's not just the clinical side I love but I feel I'm here to fight their corner. I'm at the end of the telephone if they need me, and if they feel desperate, they know they can ring me at home. That's what's really important – making sure there's a named nurse there that the children, and their parents, feel they can trust.”*





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