

Nurses in Society: starting the debate.

Oral evidence gathering

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Introduction to this report

Background and objectives

Lala & Wood market research consultants were commissioned to undertake this work by the National Nursing Research Unit (NNRU) at the behest of the Chief Nursing Officer for England's team. The purpose was to obtain oral evidence from key stakeholders of their views on the current role and potential future direction of nursing. This work complimented the written evidence gathered by the NNRU¹. Stakeholders included registered nurses and students, representing acute and community care, adult, child, learning disability and mental health. In addition to members of the nursing profession, other interested stakeholders such as doctors, academics, members of the Houses of Commons and Lords and executives of some organisations representing related professional and patient interests were included in the sample (see Appendix 1).

The purpose of the exercise was to provide input to the task and finish group on the Role of the Nurse² and to provide evidence for the Nurses in Society document³ on the future of nursing.

Interviews and focus groups were undertaken in April, May and June 2008 and were structured around the four key questions developed by the research team:

- What is good quality nursing? As a nursing professional, what aspects of the nursing role do you value or care about most?
- As a potential patient, what aspects of the nursing role do you value or care about most?
- What threats and challenges do you think the nursing role faces today?
- What do you think can be done to strengthen those aspects of the role that you care about, and how would you propose going about this?

Overview of key issues from oral evidence

- The professional community broadly feels nursing has currently lost sight of its vision as a holistic practise concerned with the patient's emotional as well as clinical experience and wellbeing.
- This reflects itself in current problems, from poor service delivery and lack of accountability, and susceptibility to adverse publicity from these, through to the perceived poor image and appeal of nursing in the outside world and particularly among potential entrants to the profession.
- Many feel the solution lies not in the apparent increasing 'medicalisation' and technical skilling of the profession, nor entirely in the move towards making the Registered Nurse role a degree-only qualification, but re-thinking what is needed to execute that holistic vision of nursing and the consequent structure of the nursing family.
- The Registered Nurse should be seen to be, and should be able to function as, a highly qualified and skilled team leader in charge of a patient's care, efficiently supported by correctly trained and skilled support workers and responsible for co-ordinating and managing all other healthcare disciplines and related agencies, ensuring the best possible experience for the patient.
- The profession should thus be aiming to plan resources, organisational structures, recruitment policies and pre- and post-registration education, better to deliver this vision.
- There was felt to be a particular need for strategies to utilise fully the abilities of all members of the nursing family, and give them clarity about individual responsibility, lines of accountability and paths for career progression. This should mean an end to the apparent under-valuing of a qualified nurse's skills, and the consequent demoralisation and attrition of the workforce.
- There should also be a new approach to monitoring and evaluating patient care, encompassing all skills, both practical and emotional, implicit in this holistic approach, and recognising the unique contribution of the Registered Nurse.

Key findings from the oral evidence phase of the consultation on the nursing contribution

1. What is good nursing?

What is good nursing?

This question elicited a wide range of responses across the sample, varying in nature, perspective and specificity. Here are some quotations from responses to this question:

“Caring, compassion, helpfulness, spending time with me”

“Care that either maintains or improves health”

“Evidence based practise”

“Having an up to date knowledge base and a positive value base”

“Teamwork”

“Leadership and management of all disciplines involved”

“Communication - with patients and carers”

“Being the patient’s advocate”

“Addressing the basics: doing for the patient what they would do for themselves if they were qualified”

“Ensuring quality of care”

“Well organised and well managed”

“Being able to assess patients well”

“Clinical competence”

“Not just reinforcing the sick patient model, but valuing them as people”

“Making a difference”

“Safeguarding children and adults”

“Looking at their priorities, rather than what we think should be sorted”

“Holism. It’s corny, but it’s right”

Despite this apparent diversity of response, as interviews developed and perceptions and beliefs emerged in more detail, there was found to be a broadly common understanding of nursing unifying respondents, all of whom are stakeholders in the future of nursing.

The professional perspective on good nursing

Good nursing draws on a range of skills

Good nursing essentially encompasses each of the following:

- professional and technical competence

“I want a nurse to do more than follow instructions. As a doctor I want them to come and tell me there’s something funny about the patient’s colour, or they’re worried about something that’s not right - being of benefit to me as well the patient, in a diagnostic role, collecting new information and observations I’m not always there to see”

(Doctor in clinical and academic role)

“The life-long learner aspect - when I qualified I thought that was it, but you’re always looking at yourself, being a reflective practitioner”

(Senior nurse in managerial role)

- empathy for the patient – including and influencing the patient’s experience of treatment

“Making them as comfortable as possible, preventing the patient from any unnecessary discomfort, physical or mental, during treatment - including discomfort if treatment is not given as efficiently or on time as possible.”

(Senior nurse in managerial role)

- efficiency, good management and organisation, including good leadership (key to nursing organisation), seamless collaboration and co-operation with other professions and teamwork, with responsibility for and communication with others.

Nursing is a holistic concept

The professional perspective, whether from practising or retired professionals, or from members of a related profession or organisation, was essentially that nursing is a holistic concept.

Most respondents defined good nursing by strong skills and competencies in patient care, delivered in an empathetic and compassionate way.

A number of people, particularly those observing nursing from related professions and bodies, commented that nurses do things differently: for any given task, a nurse’s approach or manner or touch will often be different from that of members of other professions. This was something they greatly valued about nursing, and is borne out of empathy with the patient.

The Nursing Contribution to Care:

1. Definitions of good nursing

“When I trained, it was about what happened at the bedside - the personal relationship between nurse and patient. Touching was very important and nurses were much better at that than doctors”

(Doctor in managerial role)

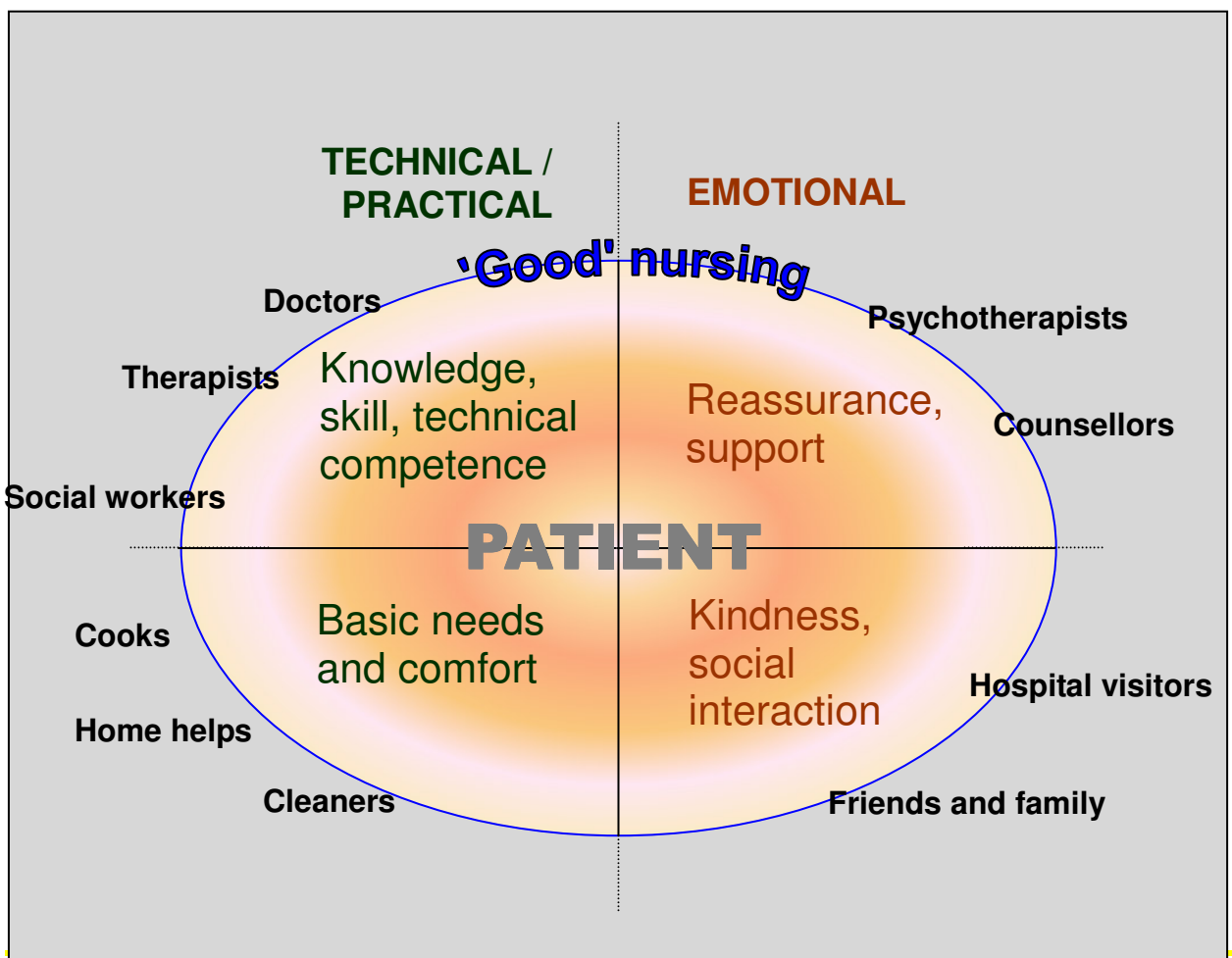
What nurses themselves universally valued most, and had motivated them to originally join the profession, is human interaction - the emotional side of care: being able to help, support and guide people, ‘making a difference’, having a positive influence on the lives of others:

“I became interested in learning disabilities because there’s a lot of injustice in the way those with learning disability and mental health issues are treated - they’re seen as a massive problem by many, which I find very distressing”

(First year student)

A key observation was that many identified nursing as the only healthcare profession with the ability and duty of taking the whole view of the patient, and through that understanding, of being the patient’s advocate in the healthcare process.

They therefore saw the unique role of the nurse as the lead healthcare profession, surrounded by and responsible for liaising with the other professions and agencies, hence the importance many attached to good management, teamwork and collaboration with others, a point of difference which many see as the link to the future for nursing.



The patient's perspective on good nursing

Responses to this question were derived either from individuals' own experiences as patients (or those of close family members or friends), or imagining themselves as patients or users of nursing services.

When considering what they would regard as good nursing if they found themselves as patients, all responses essentially centred on a good experience, resulting from a combination of physical comfort (or minimised discomfort) and emotional reassurance.

The skills that respondents as patients valued in a nurse centred on technical competence and knowledge, and good communication, listening to and addressing their concerns.

"Yes, I want to know they're well trained and expert in what they're doing, not getting my dosages wrong or fluids at the wrong rate, but also that they listen to me and understand my needs and act as my advocate in hospital, not passing things on about me which aren't true, and not assumed advocacy - they need to ask me!"
(former patient)

Technical skills were clearly very important in terms of reassuring them that the care would be effective and not harmful: most emphasised that patients need to see, and believe, that the nurse treating them is skilled and competent, and that they can place their trust in that nurse:

"It's a bit like getting on an aircraft - you assume you're going to get on one side and get off safely at the other"
(Director of health-related organisation)

But technical skills delivered without sensitivity and understanding of what the patient was experiencing would not guarantee a good experience. A sign of good nursing for many therefore would be the reassurance that someone has their interests at heart - not only are they fully competent and efficient, but they relate to them as human beings and care about the outcome for them.

Negative patient experiences also highlight key requirements

Although these perspectives are very closely aligned with their more formal views as professionals, they have in many cases very different origins, being based on real experiences of acute care. The findings include a high number of reports of sub-optimal and adverse treatment experienced even by those in the nursing and related professions, or by their close family members, which serve to highlight some of the key requirements:

Knowledge and competence – not this:

The Nursing Contribution to Care:

1. Definitions of good nursing

“Antibiotics not given when they were supposed to be”
(former patient)

Teamwork and organisation – not this:

“As a patient, the thing that struck me was the disorganisation of the ward. OK it’s very busy, but I came away with the distinct impression that the ward was merely a work site - lots of people come in, work and go again, without reference to anyone else. The only communication was writing on the records - and different people tended to use different bits of that - there was no kind of joining up”
(former patient)

Responsibility and accountability – not this:

“I wanted – and should have had – an earlier discharge – and the thing that delayed it was that the doctors, pharmacists and nurses weren’t communicating. No-one would take responsibility for organising my ongoing medication so I could be discharged – so I had to do it!”
(former patient)

Above all, compassion and empathy for the patient – certainly not this:

“My mother had a good clinical outcome, successful surgery and good medicine, but her experience was absolutely shocking, and has done untold damage to her attitude to the NHS. What people remember is the experience - no matter that I tell her it’s all fine now and she’s better.

“One day she called a nurse and was told, by this nurse, ‘there are no bedpans left. You’ll just have to go in the bed’”. This is to a distressed lady, recovering from surgery, in her 70’s.

“And she had some really horrendous experiences there that you wouldn’t wish on an animal. Those experiences are extremely damaging”
(healthcare professional speaking of family member’s experiences as patient)

A particularly striking observation here is the repeatedly heard admission that, while on the receiving end of poor care for themselves or their families, despite being members of the nursing or medical professions, many here were reluctant to complain about it to the service providers for fear of their reaction, and were left shocked, depressed and powerless by the realities of the experience.

“I did notice nurses not washing their hands and I got a wound infection. But I couldn’t (bring myself to) say anything”

“I had an overwhelming desire to get out of there before anything went wrong”

“It felt like a very dangerous place to be”

“If that is how I felt, as a member of the profession, what on earth is it like for the ordinary person?”
(All former patients)

The Nursing Contribution to Care:

1. Definitions of good nursing

Qualities and skills believed to be found in a good nurse

- Compassion and empathy
- Respect for differences
- Good communication / rapport with patient and ability to gain their trust.

“You’ve got to like people.”

(Doctor in managerial role)

- Intelligence
- Academic ability as appropriate for role
- Self-awareness - of one’s strengths and weaknesses and preconceptions; reflective practitioners
- Honesty

“Someone who is open - who tells it like it really is.”

(Director of healthcare related organisation)

“Being open and honest, even about failings in the system. Even if you forget to do something, being honest if you get something wrong. And apologising– quickly.”

(Senior nurse in clinical role)

- Ability to deal calmly with crises
- Reliability

“When they say they’re going to get your bedpan, they do it, or in the community, if they say they’re going to turn up, they turn up!”

(Senior nurse in managerial and leadership role)

- Being well organised and using resources well
- Good team worker, with sense of responsibility to and communication with other team members
- Leadership ability

In the end, you end up with Mother Theresa really!

(Senior nurse in non-clinical role)

“Mother Theresa came over as someone so compassionate, and yet she was a tremendous leader”

(Senior nurse in managerial and leadership role)

Summary of perspectives on ‘good nursing’

Despite the apparent diversity of examples cited above, all members of this professional community were essentially in agreement on the principles of “Good nursing”.

They feel that nursing is more than a job description or professional role.

All essentially described the same thing: a holistic approach to patient care, delivered through clinical skill, knowledge, professionalism, good judgement and efficiency in combination with empathy, compassion and respect for the patient as a human being.

Despite differing backgrounds, roles and experiences, both professional and personal perspectives are aspiring to a common destination: a vision of nursing as a way of practising, more than just a sum of parts (which without an awareness of where each leads can become an arbitrary list to which it is harder to feel commitment).

All respondents here shared a heartfelt aspiration for nursing, that it is **a philosophy as much as a skill set.**

And to allow this to flourish and be consistently delivered, this philosophy should be intrinsic to organisational structures as well as to individuals

The task ahead to achieve this is to refocus on this as the unique benefit of nursing, and strengthen both practical and emotional aspects to ensure consistent, equal delivery.

2. Threats and challenges to nursing

Key challenges to nursing

Respondents' opinions on the main threats and challenges to nursing could be categorised into one of three broad headings:

1. Loss of vision, purpose and identity of nursing
2. Consequent impact on leadership and organisation of the profession
3. Consequent lack of focus for development of the profession: recruitment, training and career development, as well as academic status

The key challenge: to restore nursing's vision

The overriding finding of this research, articulated specifically by many, but at the heart of all concerns, was a loss of direction in the profession: loss of an understanding of its purpose, aims and benefits, and for the individual, absence of an appreciation of their role and value within the broader system.

*"I wish I knew **now** what a nurse was. I'm not sure I know any more what the nursing profession thinks is good nursing"*

(Doctor in managerial role)

Many of the current issues and problems facing nursing are therefore believed to stem from a lack of a clear vision of nursing's role within the wider health service.

Underlying all responses to this consultation was a perception that a lack of clarity about the nurse's role is manifest (whether currently articulated and discussed or not) in all key aspects of the profession: leadership, nursing's power within organisations and the NHS, organisational and management structures, public perception, academic and research status, morale among the workforce at all levels, misconceptions among new and potential entrants to the profession, and vulnerability to the pressures of delivering current government targets and directives (although many understand and agree with the rationale for these).

These have consequences both for the quality of care delivered to the patient, and the fundamental identity the profession projects.

Impact of loss of vision throughout the profession

Nursing becoming diverted from its course

Nursing is believed by many to be becoming distracted from its holistic approach and instead, increasingly pulled towards greater medicalisation.

The current focus of the profession is seen by many to be on the 'science' or "medicalisation", rather than the 'art', i.e. promoting nurses knowledge and application of technology and clinical skills, without equally developing Nursing's excellence in people skills. (N.B. this relates to technical interventions and procedures and is not the same as nurse prescribing, which was not felt to be an issue).

"Technology is taking the talking and touching out of healthcare - that doesn't make a relationship"

(Doctor in academic and managerial role)

"The search for professionalism and sexiness has lost what nursing is all about"

(Senior nurse in managerial role)

This is believed to be evinced in two factors in particular:

Firstly, the roles and tasks nursing is developing increasingly overlap with those of junior doctors;

"There's an erosion of the nursing role as we knew it when we trained - there's always pressure on us to go and do another course that formerly doctors would have done."

(Senior nurse in clinical role)

"There's a challenge to take on more of the medical role often now - if you look at a house officer and a senior nurse, there's not a lot to choose between them in terms of what they're doing."

(Doctor in academic role)

Secondly, the move towards making nursing an all degree-entry profession. Those who believed the future of nursing was dependent upon higher level educational requirements, saw degree status as an inevitable conclusion (discussed in more detail on page 25).

However, some respondents here, both nurses and other professionals, felt that such a move may bolster the 'medical' aspect of the nursing role, which they saw as just one skill additional to the core nursing skill, holistic patient care.

The Nursing Contribution to Care:
2. Threats and challenges to nursing

Meanwhile, the caring attitude necessary for ‘holism’ appears to have become subjugated or ignored altogether

There was a belief that while nursing was pursuing medicine, the best aspects of nursing were being lost.

Many here, from all quarters, feared nursing losing sight of its real area of expertise: interacting with the patient and understanding the patient’s total needs, and using this understanding to inform all aspects of the care of that patient.

They were concerned that the way nurses deliver those vital caring aspects have been de-prioritised or forgotten, with the result that a truly holistic approach is now rare.

“Doctors aren’t trained to look at the needs of the whole patient - nurses are and should be proud of it, and that skill set, and not believe that the only way to get esteem is to do the things doctors do”

(Associated healthcare professional)

Nursing shadowing medicine was thus seen as a strategy which many felt would not deliver the best quality care:

“Nursing isn’t as ‘handmaiden to doctors’ and should get away from that hang up - it’s a completely different role!”

(Associated healthcare professional)

“In policy making, management, the whole approach, we focus on increasing technical skills, academic ability, doing masters’, new ways of working, extending the scope, etc etc. Yes, there is a point you have to look at the skill mix and value for money, but somehow it’s been at a cost. The caring side has completely gone”.

“We’ve almost created a monster. The very thing we value has been lost, and that isn’t the intention”.

“My question is: how is modernising going to translate into improving care for patients?”

(Nurse in senior managerial and leadership role)

Some also pointed out that ‘medicalisation’ is a dangerous path if it becomes the lead focus for nursing, because the potential over-supply of doctors may be a threat to it in future.

Public perceptions are weakened by high profile incidents, and are not being redressed by strong, positive messages

Lack of clarity of vision inevitably means a positive image and message are not being promoted to the public.

The Nursing Contribution to Care:

2. Threats and challenges to nursing

A source of great concern was that the negative stories in the press about nursing get disproportionately high coverage, leading to poor public perceptions of the profession.

It also means a positive message is not being conveyed within the profession itself to its members.

Loss of direction results in loss of pride and confidence

Loss of direction and an absence of positive images also means loss of pride and confidence in the profession, which is believed to be reflected in the service that is being delivered. There was a strong sense when talking to practising nurses of demoralisation and even of some questioning their decision to remain in the career.

Attrition is an increasing problem within the profession, and many believed that what remains is an ageing and/or demoralised workforce.

In turn, with public perceptions poor, and without high profile champions of the profession fighting its corner, nursing is believed to be losing its appeal as a choice for school leavers, so that those leaving the profession are not being replaced in sufficient numbers by new entrants.

Nursing is less appealing today as a career choice

Many senior professionals were concerned that strategies for attracting new entrants to the profession were in need of review, as they were based on outdated assumptions and images of the profession, or at least were not presenting a face of nursing that is relevant and appealing to today's youth.

Some felt that nursing had relied for a long time on an assumption that it would be a popular choice for young women in particular.

“Nursing was traditionally a female career. In my day, you could only be a teacher, a secretary or a nurse. Now young women are choosing medicine, or even law or banking if they're bright and ambitious and want a quality of life”

(Director of healthcare related organisation)

These respondents emphasised that young people leaving school are now faced with so many apparently more attractive choices that nursing cannot any longer assume it will be near the top of the list as a career choice among today's youth.

This means that there is an urgent need to define what's different and unique about nursing, (which once again, returns to the need to focus on the vision) and then to plan and operate with this at the forefront of the mindset.

Lack of vision has consequences for leadership, organisation and management

Nursing lacks leadership

One of the most prevalent stereotypes felt to be dominating public perceptions of nursing today was that of the 1950's matron, which is regarded as the symbol of a time when nursing was at its best.

Although few, if any, we spoke to here would join in public cries of "Bring back matron!", most saw this icon as a major obstacle in gaining the hearts and minds of the public because of its powerful emotional symbolism.

There is a reason why the key nursing role models still universally cited are Florence Nightingale, Mother Teresa - and Hattie Jacques (in her role in "Carry on Matron"). Notably, out of these three, one is not strictly a nurse and one is fictional!

"Where are the powerful nurse leaders of today?"

(Senior nurse, retired)

But the reason they are felt to prevail as images of nursing is that all possess powerful and charismatic leadership qualities and were highly persuasive figureheads and focal points for their staff - something which is perceived by the nursing profession and its allies and service users as lacking, but much needed, particularly in the acute setting, in today's profession; hence the populist cries, even if not reprised by our respondents:

"I think every copy of 'Carry on Matron' should be burned. You can't bring back the matron role as it was 40 years ago. But what's missing is responsibility - and what's prevalent now is disorganisation"

(Doctor – but frequently repeated)

"Nobody's suggesting we go back to the 50's, but we can't see the wood for the trees: what we've LOST is the unquestioning authority and executive power of that figurehead called matron, and whether we call it 'matron' or 'chief nursing executive officer' is irrelevant"

(Director of healthcare related organisation)

"You need one central point of reference. In today's world, in a trust with 20-something matrons, which happens, how can they, let alone those working for them, really know who's in overall command?"

(Senior nurse in managerial role)

This last quote then raises the issue of the impact of loss of leadership on the functioning of an organisation.

The Nursing Contribution to Care:
2. Threats and challenges to nursing

Nursing is perceived to lack power at board and management level

There was a high degree of unease and frustration heard here at the lack of power nursing has today at board and management level.

“Medicine is where the power lies and the strategic decisions are made. Of course power lies in the hands of the individual - some wards you go in and you almost have to curtsy to the ward sister - others you can walk all over them - but there don't seem to be enough entrants to nursing able to take and use power effectively”
(Senior nurse in managerial role)

The lack of power and lack of budget holding by nursing mean nursing is often no longer able to make its own decisions – even on matters where it may be the best placed discipline to do so.

“I talked to 24 disillusioned modern matrons in one trust. They said, “We can't do what we want to do for patients, we have to go to a middle manager, who says, ‘we don't have the budget’” I'm not saying we want to do away with general management, but nursing should be in charge of the patient's care”
(Senior nurse in managerial role)

“Nursing needs to regain its vision - and its power and conviction to carry that out: It's not coincidental that there are fewer problems in private hospitals which are nursing-led, and it's not entirely due to the case mix. Doctors do what nurses say!”
(Doctor in academic role)

Many felt confusion exists right up to hospital management, with a telling symptom of this being the Director of Nursing function which now often encompasses other responsibilities. Many wondered why there isn't sufficient pride and focus on nursing in its own right, as there is certainly a need and justification to retain a single focus on nursing.

This confusion, and consequent failure to assert power consistently, is felt by many to be the reason for disorganisation of nursing resources, the lack of nationally recognised organisational structures and ultimately, and most seriously from the patient's perspective, poor service delivery.

Most serious impact of loss of focus is on day to day delivery

Many here were very concerned about what happens to the 'caring' philosophy and experience for the patient, a function of what is delivered, and by whom, as nursing moves towards increased medicalisation and being a degree-only profession.

“Medicalisation is a potential threat: if you select all nurses as going to be super-specialists or consultants, and don't think about who's going to be doing the day to day patient care, you're in danger of creating a big gap left to the care assistants.”
(Doctor in managerial role)

The Nursing Contribution to Care:
2. Threats and challenges to nursing

“The way nursing’s been created as a profession, to which the medical work is progressively devolved, means that as nursing moves up the division of labour in pursuit of medicine, you get all the spaces at the bottom that aren’t filled”
(Doctor in academic role)

“Some foreign nurses (on arrival in the UK) are often shocked at how little ‘care’ they’re asked to do here in the NHS!”
(Senior nurse in managerial role)

Many non-clinical respondents here pondered or could understand the public so doing, the question: who really provides the caring on an hour to hour basis in the clinics and the wards? And those closer to the clinical arena sensed that the answer was not the one the nursing profession wanted to give, but an inevitable consequence of current circumstances: that the basic, day to day care was all too often delivered by the care assistants rather than the nurses themselves.

“Much of what I’d call ‘care’ - spending time with the patient and addressing their needs, hour by hour, is now given to the care assistants - yet the continuity, the overall picture of the patient, and the expertise may not be there”
(Doctor in managerial role)

“My concern is that nursing has gone down the university route, phasing out the SEN and using less skilled people - care assistants”
(Doctor in clinical and academic role)

i.e. responsibilities have become blurred, leading to inefficiencies in delivery and confusion among patients.

Some argued that as long as formalised training and supervision systems were in place, basic ‘care’ delivered by care assistants was by no means a negative, and care assistants certainly had their place within the nursing family.

However, the key frustration and issue here was that of the inefficient use of the very valuable resource of Registered Nurse:

“Nurses are being asked to do too much that isn’t ‘nursing’ - nor that values a nurse’s ability to deal with complexity... while at the same time, passing too much ‘nursing’ down to semi-skilled workers”
(Third year nursing student; but echoed at all levels)

Impact of loss of vision on organisation and management

Workforce planning issues

Many felt that the current nursing skill mix and level of resources is not best suited or able to handle all the basic nursing tasks.

“We’re having to cope with a situation where, rather than getting more trained and skilled nurses, we’re having to cope with a wider skill mix and having to supervise less qualified staff - who are being asked to do what they’re not adequately trained for.”
(Senior nurse in clinical role)

“Nursing is being pulled in too many directions by the skill mix issue - because it’s required to be there 24/7 it becomes a jack of all trades and a filler of gaps, forgetting its real purpose”
(Senior nurse in leadership role)

There was very little awareness among those we spoke to of obvious solutions to this situation in routine practise anywhere which could be modelled and adopted by others.

Conversely, some respondents suggested that organisational structures and restructuring can seem too much like arbitrary, ill thought-through events, with no consistency across the country, again, another manifestation of lack of clear leadership. Some felt strongly that decisions such as strategic planning of the workforce are wrongly devolved to local level, resulting in the ‘postcode lottery’ and, many feel, a loss of focus on, and difficulty in delivering, a caring experience for the patient.

“There’s a huge gap between policy and the front line, all managers hear is, ‘we’re going to restructure you’. Where is the evidence to say that current models of staff structures and skill mixes are the right ones - you need to pilot it, and then extend it. The trouble is, things are imposed”
(Senior nurse in managerial role)

“There needs to be some national guidance for nursing management so it is held accountable for the skill mix balance of the workforce. It shouldn’t be a case of ‘you decide how you’re going to deliver it’ - the outcome then is the postcode lottery. It is difficult, because you need local decision making, but they’re often not prioritising the right things”
(Senior manager, non-nursing professional)

Many were keen to point out that this is because workforce planning has deeper implications than merely efficient and timely service delivery: if resources are not planned and managed to ensure the right people are always in place to deliver the appropriate level and quality of care, patients will not perceive a truly caring philosophy permeating the service.

The Nursing Contribution to Care:
2. Threats and challenges to nursing

“If you don’t get this framework right, there is a danger of building something that isn’t tightly bound in that caring philosophy”
(Doctor in clinical and academic role)

Responsibility, teamwork and accountability

Linked to this, some respondents also perceived an absence of teamwork or of accountability for key decisions.

They felt that a lack of clear lines of responsibility or organisational structures were causing a lack of teamwork in some organisations. Inefficiencies and lack of accountability in such organisations were felt to be the result of too much work being conducted in isolation without communication with, reference to, or respect for, other disciplines.

“There’s no accountability for what they’ve done - they’re there physically, but not organisationally. They just come in and DO things, and go away again”
(Senior clinician speaking from experience as a patient)

This scenario may be the cause of major problems not being resolved quickly and effectively (e.g. ward hygiene, not only an issue which has crossed into the public domain, but is a constant source of stress and frustration to clinical nursing staff).

“THESE are the real issues that lead to the visible problems like dirty wards; nurses shouldn’t be asking ‘why isn’t the ward clean? It’s outsourced and I don’t have any responsibility’ - someone should be saying ‘I WILL MAKE SURE IT’S DONE - NOW!’”
(Senior nurse in managerial role)

“I think there’s a kind of heroism now in some highly qualified nurses - they’re juggling 6 things, working unreasonable hours, they’ll say ‘don’t ask me to do anything else’ - it’s like a Blitz mentality - ‘we’re doing so much more than we should already, so if we make mistakes, it’s not our fault’ ”
(Director of healthcare related organisation)

The combination of this “blitz mentality” with the (understandable) unwillingness to take further responsibility, means that the service is often delivered below the desired standard, under pressure, by stressed nurses unhappy about the situation and aware that they are compromising, but unable individually to do anything about it.

Some commentators also felt that the fact that nurses at even local level don’t feel able or confident to take responsibility for their teams means that the opportunity to delegate many routine tasks to skilled assistants is lost.

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“The gap and opportunity is in nursing quality-assuring care. The nurse can’t deliver it all nowadays, but is responsible for what’s delivered by the technicians - various semi-skilled tasks. But attention is not given explicitly to supervision and accountability.”
(Doctor in managerial role)

Current working practises present what appear to be almost insurmountable obstacles

There was considerable frustration at the inequity of the (perceived) over-emphasis on targets - measurement of tangibles - and complete lack of emphasis on the intangibles which are difficult to measure but still vitally important, i.e. qualities, patient experience, etc.

In consequence, some believed that these intangibles, which are what define the ‘caring’ aspects, were often ignored altogether.

Several managers and those with academic perspectives to their work discussed this issue:

“Current metrics are quantitative in nature: we tend to measure success in terms of the things we can grasp - cost, time, numbers treated, etc. But none of that takes into account the key thing about nursing: what was it like for the patient?”
(Senior nurse in clinical role)

“Therapeutic effectiveness and humanity and compassion are always in some tension. The latter tend not to be visible and measurable and tend to suffer as a result. Yet the evidence is that rates of healing and improvement are bound up with the experience the patient has.”
(Doctor in managerial role)

“As well as improving the quality of care in terms of clinical outcome, we should be trying to improve the patient experience, and thinking of how the NHS values that.”
(Doctor in managerial role)

“Caring is not weighted - you gain status as a nurse in other ways, not on assessed ‘caring’”
(Senior nurse in managerial role)

As a result of intense focus on the tangible measures and the implication that these are the only criteria on which they will be judged, some nurses reported feeling disillusioned and demotivated by being asked only to demonstrate that they meet pre-determined, quantified standards, without acknowledgement of the ‘care’ role.

“There’s so much pressure on management to deliver targets and outcomes that they’re then passed down onto the staff - that’s the culture that’s been created. That’s where the Department of Health can have influence”
(Senior nurse in clinical role)

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“Targets aren’t a bad thing - we need those outcomes. But to avoid clinical control as well is a mistake - 40 years ago, we had full clinical control, and outcomes were good. People do feel committed - but also powerless these days as to what to do”
(Senior nurse in managerial role)

Again, a lack of inspiration and guidance, whether filtering down to staff from local management, or as a result of the absence of vision from the profession itself, is believed to be adversely affecting service delivery.

In this case, its effect is felt to be to make already demoralised nursing staff even less able to deal with the pressure of achieving the prescribed targets: these were frequently described by staff as an obstacle that had to be overcome, such as the constant mention of the frustrations nurses feel at having too much paperwork to do.

“I think a key challenge is getting staff to do what they are trained to do and not what saps valuable time! It’s difficult, particularly with our culture of litigation, which means having to record everything. And that’s suppressing innovation, because nobody will take risks”
(Senior nurse in managerial role)

Some clinical staff expressed the view that information collection and record keeping (“paperwork”) is particularly frustrating when it is - literally - paper-based and thus often unnecessarily repeated, as well as vulnerable to damage or loss. Some feel this problem may be improved by the use of centralised electronic records.

Stretched resources

A threat many mentioned was the declining and ageing workforce. As the workforce ages and retires, too few newer nurses are thought to be coming through to replace them, which in turn is putting increasing pressure on those left - on the ground.

“I’ve worked for 4 years in a big city hospital - it’s MADNESS on the wards - you just haven’t got time to juggle all the tasks”
(Nurse in clinical role)

“The finer things can’t get addressed because of the pressures - like talking to a patient who’s newly diagnosed with terminal cancer and hasn’t taken it on board”
(Senior nurse in clinical role)

However there were those who still feel that the blame lies not so much on the workload placed on nurses, but – once again - in organisation and leadership’s failure to provide them with direction and priorities:

*“The time argument is nonsense. Nurses don’t do the basic care because they don’t **want** to any more - not because they don’t have time, and that’s because they’re not inspired or led from the top by example –so they’ve lost the will”*
(Senior nurse in managerial role).

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Demoralisation.

Protection and care of the workforce is a key management role, but due to the pressures outlined above, many sensed a problem with an increasingly demoralised workforce.

Essentially, they felt that lack of a vision, and of a high profile and inspiring leadership protecting and promoting that vision, will inevitably lead to a detached and dispirited workforce, a situation which many feel must urgently be addressed before current levels of attrition become unmanageable.

“The (challenge is the) burn-out rate - and often people who are burnt out are the ones who stay in the job because they have lost the impetus to leave”
(Senior nurse in managerial role)

Instead, a combination of pressure without a clear goal or explanation (e.g. why the targets are so important), and loss of self-determination and self-esteem, means that the nursing workforce generally is feeling demoralised and lacking pride, and this is being projected to the outside world. One manifestation of this, cited by several respondents, was the way the media so readily reports allegations of unprofessional behaviour among nurses from members of the public.

“I want to be proud of the nursing workforce. I get very distressed when I hear about them being promiscuous. That then reflects on their public persona.”
(Director of healthcare related organisation)

Others also perceive the profession itself – even inadvertently – does little to lift the collective mood:

*“I don’t want nurses to be **victims**, which they have in the past. If you go to the RCN congress, they’re always going on about how downtrodden they are. They should be **proud** of being a nurse!”*
(Senior nurse in managerial role)

In conclusion, the current issues and problems facing nursing are believed to stem from a lack of a clear vision of nursing’s role within the whole health service, and without it, none of these issues is seen to be easily or even imminently resolved.

Development to deliver the vision

There was considerable debate and thoughtful insight from those we spoke to around the issue of how the profession can gain the greatest advantage from degree status.

At all levels from within the profession, as well as external commentators, many cited the planned degree-only status for nursing as a potential challenge, and sounded notes of caution about unreasonable expectations

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from it or unforeseen consequences of its universal adoption as the entry point for the nursing profession.

The degree is vital for the status and future of the profession

The existence and value of the nursing BSc degree was unquestioned here. Professionals and leaders in and around the nursing profession saw the degree as essential to the professional status of nursing, and a vital benchmark for standards, and as such must continue to develop and evolve. Indeed, many pointed out that nursing cannot be considered a 'profession' without it.

The profession therefore believes degree nursing is the way forward for a stream of people.

However, they also see that it is important to get full value from degree status, and that it is not seen as a panacea for problems which might be better solved with other solutions.

Issues surrounding nursing becoming a degree-only profession

Interviewees raised a number of points to consider, and urged caution before completing the educational and professional development strategies.

(a) The vital elements of care – empathy and compassion – are not conferred by a degree yet should be key recruitment criteria

“The system tends to value nurses in terms of how many qualifications they have, not the care they deliver”

(Non-nursing professional)

“Why do you need a degree to empathise?”

(Senior, non-graduate nurse)

They feel the distinction should be made between the need for 'nursing' in its broadest sense, i.e. patient care, where arguably there is an acute shortage of labour, and nursing the **profession**, a group of expert service providers educated in and responsible for the highest standards of care and the management of all who deliver it.

“In my opinion, Project 2000 only got it partly right and was based on a flawed assumption - that status can only be achieved for nursing by giving everyone graduate status. What they forgot was, nursing isn't an academic discipline, it's a philosophy, and much bigger world than that, and the highly educated and gifted leaders at the top are just the academic branch of this world. And in its rush for higher status, it forgot about the job it was based on, and who was really needed to deliver that work on a daily basis.”

(Senior nurse in clinical and leadership role)

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“Nursing is not an academic subject on a daily basis. If you’re practising as a nurse, yes it’s important to have it, but it’s not all of it”
(First year student)

Many felt that much of the day to day basic care doesn’t demand a degree to be efficiently delivered.

“Professional nursing has always been resistant to having a semi-skilled role alongside. I was never enthusiastic about abolishing the SEN. I think a lot of important skills and people were lost, that weren’t valued as they should have been and now could have a very important part to play”
(Doctor in academic role)

“How is an all degree profession going to improve patient care? By making everyone get a degree, how are those other aspects NOT going to be lost?”
(Non-nursing professional in managerial role)

“The care is so important - patients say, the nurses were the people who made it bearable for them - they don’t think about the person who worked out the correct dose.” (First year student)

(b) By becoming a degree-only subject, nursing will be entering a different arena and competing on different rules in future – and thus may not attract the right candidates for the right reasons

Instead of the ‘caring’ ethos, some were concerned that the nature of what the nursing profession aspires to and wishes to deliver has changed. Some even felt that we are now on a course of creating a group of highly qualified ‘healthcare executives’ - not ‘nurses’ in the traditional sense.

Several nurses, both senior and newly qualified, and some non-nursing professionals, had concerns that a degree selects for types of individuals inherently suited to higher academic, managerial or leadership roles and less obviously prioritises ‘caring’ per se, while those who might be excellent nurses were excluded.

“I’d have thought it was a good aspiration to be a good nurse in the caring tradition - if the aspiration is to be a hospital manager, goodness knows you could train them differently.”
(Non-nursing professional in leadership role)

There was a suspicion that some applicants today already see a nursing degree as an easier route to a BSc than some others, helped in part by the bursary if they start on the diploma course. Critically, this means it will now come ‘onto the radar’ merely as a BSc option for those who might never have considered nursing practise as a career, and, as many were very keen to point out, will not work in nursing once qualified but will seek higher paid graduate careers elsewhere.

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Even more frustratingly, interviewees suggested others who are highly motivated and temperamentally suited for nursing might be excluded on academic grounds.

(c) Degree status alone does not solve the current issues of the need for a vision and greater resources

The real reasons for the variation in standards of care were felt to be essentially

1. that too many people are expending too much effort without clear enough guidance - including how they individually contribute to the bigger picture;
2. that there are insufficient human resources to deliver routine basic care.

The concern – and the challenge – is that the nursing degree is exploited fully to allow both of these issues to be resolved.

Clear guidance throughout nursing would be dependent on

(i) a vision which permeates all thinking and actions within the nursing role and to which everyone in the nursing family is committed; the evidence is that they are, or will be, because it is essentially the reason they all give for coming into nursing. However, it is by no means clear that current entrants – or perhaps more importantly, those who dismiss or do not even consider nursing – are equally aware of that vision as the driving force and ethos for the nursing degree.

(ii) there being enough leaders to execute and protect that mission - and they are the graduates.

One of the current criticisms of nursing's structures is top-heavy management without effective leadership, and making all nurses 'chiefs' poses problems for basic principles of command structures, a lack of which is felt to be at the heart of many organisational issues currently. In short, there need to be followers as well as leaders, and all-graduate entry was felt by many merely to be a bigger version of the current principle, on a smaller scale, of large numbers of matrons without sufficient individual executive power.

(d) There are insufficient funds to boost the workforce in the necessary numbers with all-graduate Registered Nurses

Even if different structures were devised, possibly making each RN more autonomous, there was the reality of budgets in today's world to consider. Looking at the need and the available resources side by side, many felt it is difficult to envisage a future where all of the nursing function is delivered by highly trained, expert RN's:

"It's a fantasy that a ward might be staffed ONLY with skilled RN's. They're too expensive - AND too skilled for much of what is vitally needed"
(Doctor in academic and leadership role)

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However, it is important that these highly qualified leaders can instill and monitor the right approaches to patient care among their teams, some suggested, by supervising small groups of support staff and thereby instilling their training and the nursing ethos, which would allow greater value to be gained from the investment in each RN.

Many fear the profession has been forgetting what's really important about nursing, and felt that allowing RN's to be guardians of this caring philosophy would help put nursing back on track.

(e) A degree is, or should be, an exclusive standard, which by definition means limited numbers

Given the budgetary constraints referred to above, making the profession graduate-only was felt to be likely to create further difficulties if aiming for both quantity and quality simultaneously.

It is not difficult to imagine that stipulating that all service providers should have degrees might be expected to have the effect of further limiting entry into nursing at a time when numbers are already squeezed, an issue many here regarded with much concern, when what is needed is a widening of entry points to fill all the necessary roles within the nursing function.

Students here also emphasised that the degree option is perceived as difficult to access, both academically and financially.

Out of 14 students interviewed, all were doing diploma courses and most intending to transfer to BSc in year 3 - because of the financial implications, yet all recognise the worth of the BSc in career advancement terms:

"I did the diploma for the bursary, even though I got the grades for the degree"
(First year student)

"I enrolled to the BSc course but downgraded to the diploma to get the money, basically"
(First year student)

"We all know the BSc is a more transferable degree, with skills desirable to any employer - whereas the diploma may be more specific to nursing"
(First year student)

"There are no other advantages to doing the diploma - only if you're not clever enough to do the BSc"
(First year student)

(f) Widening access to the degree could create the impression of lowered standards and thus damage its credibility

Leaving aside the issue of the need to increase recruitment, many here felt that from the point of view of the **profession**, academic stringency might be no bad thing.

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Many respondents emphasised that it is a duty of the profession and its constituent bodies to maintain and raise standards, and so were concerned that widening (which to many implied relaxing) entry requirements into the profession in order to increase participation could have the opposite effect. This was of particular concern to those who already worried that nursing lacks the rigour of other professions in terms of formalised training structures and academic research.

“This may not be the most palatable view at the moment, but I wouldn’t perhaps have given everyone a degree, but allowed the brightest people to develop on the academic research side - and not go through the hands-on, practical route. Where is the core of high-flying, highly academic people who could do research into nursing?”

(Doctor in leadership and academic role)

In summary, although the nursing degree was regarded as valuable and necessary, and the way forward, there were many who felt there are still key issues to resolve prior to nursing becoming a degree-only profession.

Promotion of the profession for recruitment purposes is currently a weakness

An important threat and challenge frequently posed was the promotion of nursing – the way the profession presents itself - to career seekers. Evidence from new entrants indicates that nursing is not widely promoted, aspired to or even thought about among today’s school leavers:

*“At my school careers talk, when they asked if anyone was thinking of nursing, out of about 200, 3 put their hands up. The rest weren’t even **thinking** about it”*

(First year student)

“I think it’s not seen as a suitable occupation because of stereotyping - going back to ‘matron’ and the disasters of the past”

(Senior nurse in clinical role)

Related to this, and highlighting a significant opportunity for the profession to promote its vision and identity, was the mismatch between the expectations of new entrants and the reality they discovered.

Current students in this sample mentioned that drop out rates among the students on their courses had been much higher than they expected. They felt the reasons for this centre on the fact that many entrants have limited or inaccurate expectations of the course, because not enough information is available or provided beforehand to prospective students. Even arguing that it is any student’s responsibility to research their career and course thoroughly, virtually all felt there was little available to them at the time that could have prepared them for the challenges and unpredictability of nursing student life.

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In terms of attracting more high-calibre degree students, many felt the key lay in making caring more aspirational, rather than pitching nursing, as now, as an alternative to medicine, an associated profession or a medical sciences degree. They were strongly against allowing the myth to continue to be perpetrated (in the vacuum created by an absence of more solid and strategic communication of the nursing vision) that it was an 'easy' BSc to gain, academically as well as with the financial advantage of a bursary, that would then be a passport to other (and higher-paying) graduate career opportunities.

Challenges in pre-registration training

Another reason for the perceived high drop out rates was felt to be training courses not meeting needs or expectations.

For some, there were issues around the structure and content of courses: uncertainty and inconsistency of theory versus practise, or lack of relevant practical training prior to or during clinical experience.

It was felt by some students and nurses in clinical management roles alike that some courses need restructuring to better reflect the core competencies required, as current course structures and content are not necessarily delivering 'rounded' nurses. Technical competence is part of 'knowledge' and understanding the experience of intervention from the patient's perspective - so it was felt to be vital that a student experiences that as soon as possible.

"It's always difficult, because we want nurses to be better educated. But my head of nursing says she has to teach them nursing when they come out of nursing school!"
(Doctor in managerial role)

"Our course isn't structured and can be quite variable - some nurses won't expect me to look after my own patients, others delegate as if you're a healthcare assistant, and you never know which it'll be. I don't know if it's not clear for the mentors?"
(Second year student)

"I've been asked on wards to give an injection and I've never done one - there wasn't the opportunity to do any on the day I was supposed to learn it!"
(Second year student)

Another issue felt to need resolution was that of students not given sufficient emotional support during clinical experience.

"Nothing prepares you for how hard it's going to be"
(Newly qualified nurse)

"I knew it was going to be hard - I didn't know it would be this hard"
(First year student)

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The problem arises when they are not given the example of the professional skills they are supposed to be learning.

“People aren’t acknowledging me as a team player. This ward has awful team morale and made me so miserable I just don’t want to be there”

(First year student)

“I feel at the end of a shift, everyone should say thank you to everyone, whether they’ve interacted or not. You’re dealing with some heavy things and you need to be nice to each other. The trouble is, they don’t remember what it was like to be new”

(First year student)

Some acknowledged that they were experiencing the reality of life on the ward that they will face once qualified. However, they also reasoned that when students are so unprepared for such realities that they drop out, there is a need for education providers to discuss with them the potential difficulties and warn them of what to expect. Yet none of the students or newly qualified nurses we spoke to felt that the emotional pressures had been properly communicated to them.

Professional training and career development

Post-registration education and training was highlighted by some practising nurses and managers to be under-funded, and worse, not taken seriously by the profession or ultimately, by the NHS.

“Where the health service has gone wrong is that nursing training has been cut to save money, and that’s had negative consequences”

(Senior nurse in managerial role)

A key criticism is that, unlike post-registration medical training, nursing training is not a structured process and there is no automatic training provision built in to career development: nurses have to fund and plan it in themselves.

“There’s nothing like the levels or consistency of funding provided to other professions, e.g. doctors”

(Senior nurse in clinical and leadership role)

“Doctors are forever going on post grad courses, but I don’t know how much nurses have”

(Doctor in academic and clinical role)

“MSc and PhD are an integral part of education of other fields - but they’re not assumed for a nurse, just added on at the end”

(Senior nurse in leadership role)

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Beyond training, there is not felt to be sufficient reward or recognition to keep the best talent in clinical roles, and conversely, management is generally acknowledged as the destination for the highest achievers:

“Practise nurse teachers - they are clinical leaders but they’re being sucked into management jobs which are relatively higher paid - but why not the same for clinical leadership?”

(Nurse in senior managerial role)

The role for specialisation

In both pre-registration and post-registration education planning, some felt that the emphasis has moved towards what nurses would like or want and what the profession wants them to be - which many feel is not the same thing as what should be being delivered for the patient. In particular, the issue of specialisation was raised.

Specialisation is unquestionably seen as very important; indeed some feel there are currently not enough specialists to deliver the required service.

“Between 10pm and 10am there was not one nurse I could get access to who knew what to do. Then I met the stoma nurse, who was magical, perfect. Within a day she had taught me how to manage it. So why couldn’t she teach the nurses on the ward? It’s good to have specialist nurses - but NOT good if it doesn’t lead to shared knowledge so patients can’t always access what they need”

*“Later I asked her why it was like that - she said, “someone has to go on a course, and to most people there’s no incentive, coz you’re then the one that gets lumbered!” But I don’t want to know if they’ve made it their life’s work - continuity of the person is of no interest to the patient - it’s continuity of **care** that matters”*

“So - don’t sequester too much expertise into people who can’t be there all the time”

(Doctor in academic and managerial role)

However – the problem perceived by many here, particularly currently practising nurses and those in management roles, is that specialisation, rather than general nursing, is seen as having higher status and as being the route to advancement, and that generalisation should be afforded similarly high status to help develop and value those committed to this important role:

“Some nurses may be lost to the NHS because they can’t develop - they’ve fallen by the wayside because they don’t want to do all the specialisation.”

(Nurse in clinical role)

“People should be given options if they want to stay in and develop general nursing.”

(Senior nurse in managerial role)

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“Financial remuneration seems to be linked to acquiring ever higher clinical skills. But if someone is an excellent ward manager and communicator, that should be recognised and rewarded.”

(Non-nursing professional in managerial role)

Importantly, it was felt that this can result currently in training and development not always prioritised to match the reality of practise:

“I think it’s very important that professional training is mainstream. Nowadays there can be training in many important areas, e.g. infection control, first aid, manual handling - all really important, but are they more important than, e.g. breastfeeding - which may not be prioritised so highly?”

(Senior nurse in clinical role)

Low profile research and modest academic status

Finally, a complaint from some, particularly in other professions, was that nursing seemed to lag behind other medical and scientific disciplines in terms of the status and prolificacy of its published academic research.

“How do they get their research act together? Because it’s never been a strong point, but without good research, you can’t take any profession forward.”

(Doctor in academic and clinical role)

Some felt that unlike the medical Royal Colleges, there was no such equivalent in nursing and this was partly to blame:

“The problem with the RCN is it’s not like the medical royal colleges - it purports to be a professional body, but it’s also a trade union, so really it’s not sure what it is”

(Senior nurse in clinical role)

This leads back to the need to develop academic nursing - which presents a challenge - and a potential conflict - in terms of the qualities sought in entrants to the profession, and highlights the need for candidates of the highest academic ability, i.e. the BSc students.

3. Suggested ways forward for nursing

Respondents had many ideas, hopes and aspirations for ways nursing could develop in future, some of which were direct responses to currently perceived threats and problems, as above.

The most important and frequently mentioned, and from which many other actions would result, was the need clearly to define and promote the vision for nursing.

1. The key task ahead: restore focus on the vision for nursing

Many saw the necessary starting point as being to clarify and update the vision for nursing, both to the profession and externally.

“Somewhere there needs to be a distinct nursing perspective, different from and complementary to, the medical perspective.”

(Doctor in clinical and academic role)

This would then help to end the confusion and currently unsatisfactory situation of nursing appearing to aspire to be a second medical profession, by clarifying what nursing is and does.

“We want a team of complementary skills, not competing skills - to provide a firm foundation”

“It’s time for nursing to get on the front foot, and not be apologetic about what it uniquely does”

(Doctor in clinical and academic role)

“We need serious promotion of the role of the nurse in the 21st century - show it as a dynamic opportunity to deal with really complex personal issues for individuals. In acute settings we’re going to be dealing with huge complexity, but in a rural economy, people are working in isolation, and care comes closer to home. So there needs to be an awareness of the different challenges nursing faces.

(Senior nurse in managerial role)

“We need better public education on what professional nursing is, as opposed to support teams and carers’ contribution - to show what a team leader does and these people support that role”

(Senior nurse in managerial role)

The Nursing Contribution to Care:

3. Possible ways forward for nursing

Key questions which need to be addressed in developing this vision included:

- What is it that only nursing can deliver?
- What is important to celebrate and communicate about it?
- Why should someone come into it?

The answer was felt to lie in the holistic philosophy of patient care, with an empathy for the patient or person which critically would inform every interaction and intervention of the care they received.

This clarity would then guide and inform policies, from leadership and external PR, through planning of organisational structures, to developing the academic discipline of nursing and attracting bright thinkers to become tomorrow's leaders and academics.

Many practising nurses already possessed the vision, and their intrinsic understanding of it was evident in their comments:

"(We need to see) the art of nursing being valued as much as the science"
(Nurse in clinical role)

"Bring a sense of pride and status into the care function: make it aspirational, admirable to be a person that others take comfort and support from - make it sexy again to be an inspiring, leading, caring person - as much as it is currently to be a 'nurse consultant'"
(Senior nurse in clinical and managerial role)

"Being able to communicate with people should be given as much credence as cannulising or bowel scoping".
(Nurse in clinical role)

2. Nursing must regain control at management level

A key issue throughout this consultation was the need to identify and overcome the barriers which currently prevent the voice of the nursing profession having equal weight and power to that of others in the world of healthcare.

Many believed this would follow from achieving clarity of vision, allowing the profession to reset its course and start to make progress.

“Nurses should take power back into their own hands and restore their pride!”

(Senior nurse in managerial role)

Most respondents voiced or recognised the need to strengthen leadership at all levels, each level being a guardian of that vision, via:

- fewer but more powerful matrons/senior managers needed who have real responsibility and decision making power.
- a strengthened consultant nurse role
- fully trained and supported RN's, who feel able make executive decisions as and when needed around patient care

Beyond day to day running of services, many were very concerned that nurses should be better represented in decision- and policy-making.

“More done by working with professional bodies”

(Nurse in clinical role)

In relation to this, some recognised a need to develop the professional bodies to reflect Nursing's future aims and aspirations.

Several (both within and external to the profession) suggested boosting the RCN's role as an academy of standards, as much as a trade union.

An immediate task, and benefit, of strengthened leadership would be to restore pride in the workplace and in the profession externally.

“I overheard a conversation on a train between two women - it took one quite a long time to find out the other one was a nurse - she didn't seem to want to say! We need to re-energise the passion in the workforce, who are currently demoralised”

(Director of healthcare-related professional body)

“I'd like to see nurses as advocates for their own profession - not guilty or feeling they have to take the blame for the profession's current mistakes”

(Senior nurse in leadership role)

“We have to find ways of getting positive messages to those at the coalface. And make the outside world, as well as those connected with it, proud of the profession too”

(Senior nurse in managerial role)

3. Strategic plans are needed to deliver that vision via organisational systems and structures

The developments felt to be needed to address nursing's profile and achievements fall predominantly into two main areas:

- Delivery of care
- Professional and academic development

There is a legitimate need to review the academic aspirations and needs of the profession, to ensure the recruitment of the brightest who are able to take on future research challenges, raise Nursing's academic profile, and that of the profession in general.

However;

The major need currently is perceived to be in the delivery of care.

Moving towards raising standards in care

In line with the holistic vision of good nursing, the consensus was that standards would be greatly raised if nursing was reinstated and able to function as the lead profession in the care of the patient.

"Healthcare is delivered by teams - it may be appropriate for the lead to be taken by a nurse"

(Doctor in managerial role)

"Most of the time, healthcare is not about saving lives or even legs. So in those situations, nursing is what you want and should be reflected in the service that is offered. Very little healthcare is the acute emergency"

(Doctor in academic role)

Underlying this should be the principle of patient focus, i.e. ensuring all procedures, systems, interventions, experiences etc. are delivered in the most effective and compassionate way possible for the patient:

"Carefully planned teamwork should allow a patient a dignified or good or tolerable experience, being planned so it always keeps the person, not just completing the tasks, at the top of the agenda"

(Senior nurse in managerial role)

The objective then is to review structure and policy precisely to ensure that the correct staff are in place at every point to deliver that vision consistently in all areas of the health service, and that greatest value can be obtained from the education and skill of the Registered Nurse.

It was suggested one way of tackling this would be to analyse the current problems within nursing and healthcare delivery and identify the causes

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behind each major issue (e.g. patient's experience of care in hospital, most efficient use of Registered Nurses, management and leadership in acute and primary care, academic research, etc) in order to create strategies to better deliver each specific role or address each challenge.

Here, there were opportunities identified in every area:

- Workforce composition: more clearly defined and effectively executed roles
- Recruitment
- Pre-registration education
- Professional development

“Too posh to wash?” - The need to reconfigure the workforce to better meet current and future needs

The many concerns about the composition and deployment of the current nursing workforce is illustrated in one emotive and currently much discussed issue, that of highly educated new graduates being unable or unwilling to get involved with basic care. Contrary to the majority of comments, one junior nurse argued: Is 'too posh to wash' actually the responsible view?

Her argument is based on the issue of best use of resources.

One of the current key problems is poor organisation of resources, when highly qualified nurses become side-tracked by non-skilled tasks, because of urgency and need. The nurses themselves were the most vocal group in lamenting this situation and felt considerable frustration at frequently having less patient contact than they feel patients need – and they the nurses would like.

Although all nurses want and value close contact with patients, and many feel it is important that RN's should spend more time with patients than they do currently, one argued that best use of resources means highly qualified nurses have to have some management role too. This means that they should equally be able to delegate the simpler tasks when appropriate, and use their expertise to take an overview of all the requirements of individual patient care. In other words, not 'too posh to wash', but 'knowing when to wash and when to get others to do it' might better describe the ideal.

In fact, views of many concurred with this, although they tended to approach it from a different perspective. Whether managing or being managed, inside or external to the profession, most perceived some need to re-organise, rationalise and define roles and responsibilities better to meet tomorrow's needs:

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“Yet more ‘directives’ aren’t the answer. We need action - real structures of people actually ‘doing’, clear about what they’re doing, accountable for it, and doing it on a daily basis”

(Senior nurse in managerial role)

The aim would be a workforce clear about and able to be effective in their individual tasks and responsibilities, with clear lines of management responsibility visible to every member of the nursing family, which would provide the necessary support and guidance to all and remove doubt and lack of accountability and reduce demoralisation.

Revised administrative and support systems to ensure greater efficiencies and use of resources

When considering ways of targeting the efforts of highly trained and skilled Registered Nurses to where they are most needed, i.e. team leaders in patient management, many concluded that this includes interacting with the patient in traditional ways, but also delegating some labour.

Some suggested tackling the currently difficult area of administration, with the aim of reducing nurses’ workload.

There were two suggested routes here.

1. Improved electronic records systems to remove the burden of paperwork
2. Trained administrative staff to assist in completing non-clinical information (including populating basic background and demographic details on each patient admitted); nurses would then just have to update clinical records on each patient, which would all made easier if these were fully electronic.

Strategic planning of the workforce

The main need, however, was felt to be in redefining the essential tasks within nursing, to ensure that Registered Nurses were always able to be most effective where needed.

Many in strategic or managerial roles concluded that there is a need to review constituent parts of the nursing role and create ‘role model portraits’ for the whole nursing family, showing precisely what is needed in terms of people and policies to deliver superlative day-to-day patient care in all settings.

(Some felt this could possibly build on Agenda for Change role models; there was some reference also to NMC ‘Essential skills clusters’ - aiming to identify areas of deficit in skills - including care and compassion, and communication).

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Many also felt that there is a need to make this a nationally consistent structure, carefully planned to ensure that all tasks within the future nursing role are clearly designated. This would give every member of the nursing family clarity, and manage expectations about different named roles, thereby creating certainty for every individual about their own role and what is expected of them. This would also have the advantage of giving individuals direction when seeking to move and progress in their careers, and making it easier to monitor and maintain consistent standards nationally.

Nursing needs a wider academic and skill base

The Registered Nurse was clearly seen by all to have a pivotal role in any nursing organisational structure of the future, and the nurses consulted at all levels were in favour of reinforcing the leadership role of the registered nurse, ensuring the full development and utilisation of the talents of graduate nurses, including strategic and management roles.

However, many also felt that this role needs the support of associates of various types.

A common view was that there should be more opportunities to make proper use within the nursing function of the abilities and skills of non-graduates in supporting roles, not only to resolve current understaffing issues, but also, to ensure that the talents of those who may be unable or unsuited to access higher education would not be lost to the profession, which virtually all agreed, was much more than an academic discipline.

The vast weight of opinion here was in favour of development of an 'associate' level within the nursing family, e.g. "*Associate nurse*" or "*Skilled care assistant*" role, assisting and supervised by, Registered Nurses, but taking on more labour intensive and administrative roles to allow the Registered Nurse more time for both patient interaction and leadership.

"There's a line between the graduate nurse and everyone else. But there must be space for a foundation degree nurse who works alongside them. The graduate nurses should have a supervisory role in relation to a workforce with well-defined but sub-ordinate skills"

(Doctor in academic and clinical role)

Why the associate nurse role was so widely discussed

Senior nursing leaders and managers were determined that any restructuring of the profession must strengthen the effectiveness of the registered nurse and the status of the profession, and not detract from it, which some feared if there was any hint of nursing being 'downgraded':

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‘Part of me doesn’t want to differentiate the tasks because there’s no such thing as basic nursing, just nursing. If you’re recovering, you just want looking after until you can go home, then maybe a less skilled person can look after you’

(Senior nurse in managerial role)

However, the idea of assistants and specifically designated workers supporting Registered Nurses is widely seen as a possible solution to address previously discussed challenges:

1. Not everyone - including otherwise well qualified people - will be able to access the degree course required of registered nurses (page 28)
2. It was not seen as necessary, desirable or even possible to spend what are limited financial resources to educate everyone to fulfil the entire nursing role: much of care can, and many felt, should, become a specialism with simpler entry and educational qualifications in its own right – possibly leading to a new foundation level.
3. Such a grade could differentiate and therefore enhance the status of the graduate registered nurse. This could then have two entry points: via foundation level or direct, fast track entry via BSc, echoing the different routes of Diploma and BSc currently available to students.

NB. Many were keen to emphasise that an associate role would present no threat to the professional status of the Registered Nurse and on the contrary would help boost it: all in the nursing family possess the special and valuable ability to care, but only the graduate RN has the academic status necessary to take a strategic overview and management or leadership role, and act as guardian of standards.

However, they also felt that all the parts of nursing care should be recognised as valuable skills with a part to play in raising standards - even those currently performed by ward domestics.

‘More recognition and importance should be given to those skills - even that they ARE skills’

(Senior nurse in leadership role)

Many suspected that the more ‘basic’ skills aren’t valued only because ‘care’ itself is not fully understood or valued.

And there was a heartfelt belief among many, that the way to attract both sufficient support staff and academic high flyers, is to make caring a more aspirational basis for a career.

Recruitment

Several of those in managerial roles identified an opportunity and possible need for new approaches to recruitment strategies, to ensure all designated levels within the nursing family attract, and are filled with, the best possible candidates.

A number of ideas were put forward, but key principles were that more status should be given to Registered Nurses, while also opening up the nursing family to more people who aren't leaders but have the flair for nursing and strong abilities to show compassion and empathy even in the delivery of simple tasks that help the patient and create the experience of care.

Recruitment criteria for 'the nursing family'

One popular suggestion was that recruitment criteria should now take into account personality types, characteristics and motivations appropriate to different roles as well as quantified, academic measures, helping all candidates to access the training for their chosen career path, and helping the profession obtain a pool of higher quality workers at all levels:

"All have to be caring and interested in people - select AND train on that basis"
(Doctor in academic and clinical role)

This might mean wider/ more inclusive and flexible criteria for admission into the nursing family, perhaps via more imaginative assessment techniques (psychometrics, etc.) for identifying individuals with excellent personal qualities.

There would be two potential benefits here, both addressing current problems:

- those applying for BSc courses would be selected on the basis of personality and suitability for nursing as well as academic achievement, which many (within and external to the profession) suspect is not the case currently; drop out rates might thus be expected to be reduced
- a wider pool of highly motivated individuals with excellent nursing potential but who perhaps lack formal academic qualifications could thus be able to access nursing.

At the same time, it was felt that more stringent entry requirements into the profession are needed at graduate level, both to ensure the highest calibre entrants, and to deter those with the misconception that nursing is an 'easy' BSc.

External marketing of the profession to career seekers

Many also highlighted the need for more robust and aggressive recruitment activities and more accurate and inspiring communications promoting nursing as a career to the external world, including the diversity of career opportunities.

Some suggested focusing recruitment activities on promoting the key skills, status and inherent job satisfaction of nursing. This would be based on the vision of nursing as a holistic discipline involving a wide range of skills.

Also key was the need to widen access to, and promote, pre-entry information and experience, allowing potential entrants to make more informed choices, in an attempt not only to attract more suitable candidates but to reduce drop-out rates.

“You should have to start by doing a healthcare assistant role or another practical thing, before you end up committing to it. People don’t understand what they’re getting into”

(First year student)

4. Future needs from nursing education: views of educators, employers and students

Related to a need for a broader approach to recruitment as suggested above, some felt that more accessible education programmes were needed, at all levels, even pre-entry, allowing wider access into the career, and better customised to the needs of entrants.

Although many were very committed to the idea of identifying, recruiting and training at foundation level those with the right personal qualities who might not otherwise have academic (or financial) qualifications for admission to a degree course, at the same time there was a strong awareness that there should continue to be opportunities for all to progress up the academic scale according to ability and motivation:

“We are currently trying to get people up to NVQ level 3, which gives access to a nursing course. We need to give people support in transition to a nursing degree, which could be financial. We need to take them from naturally caring / nurturing to intellectual rigour

(Nurse in managerial role)

Development of pre-registration education

At all current or future pre-registration levels, many feel education can and should better reflect the realities of patients’ needs and the nursing vision, in particular, by developing the practical side as strongly as the theoretical.

There was clearly a need for more and better trained support workers, so that Registered Nurses could allocate tasks with more confidence, knowing that they could delegate to and rely on a person properly trained for the task.

The form this type of education might take was not clearly visualised, whether at a broad foundation level, or in terms of narrower specialisations for which support workers were more highly trained, rather than being generalists. However, there was a strong feeling that some constituent parts of the total nursing function could be successfully taught to a wide range of able carers.

The main need however was felt to be for broader, more extensive and more systemised practical clinical training for degree students: as well as learning the technical skills, involvement with patients at this level provides invaluable insight into the patient’s experience, which is necessary for a holistic perspective

“We need more ward-based and people-based training”

(Senior nurse in clinical role)

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On the subject of ensuring teaching reflects the holistic nature of nursing several senior nurses were adamant that care **can** be taught - via demonstration and inspiration.

“Reinstate wards as classrooms!”

(Senior nurse in leadership role)

Key to the success of practical, holistic training should be the identification of outstanding role models for learners, and closer and more formalised relationships between these ‘Super Mentors’ (or clinical teachers or link tutors) and the students.

The current students interviewed all felt this was a major area in which they would appreciate more support, both in terms of the educational benefits and in terms of giving them more confidence as they began their careers, on the wards.

Professional development post-registration

Qualified nurses, and their managers, felt there was a need to improve opportunities for professional development, led by more and better post-graduate education or continued learning at other levels.

A major criticism, and strongly felt suggestion for future development, was the need to formalise structures of ongoing, post-qualification training, and improved opportunities to access the next career level, as is done in medicine, including formalised study leave:

“They should have the same opportunities that doctors are given - study leave, the support they need, opportunities to go off site, financial support, etc. Doctors do have a budget, nurses are normally supported by Johnson and Johnson or someone! They have to help themselves.”

(Doctor in clinical and leadership role)

In reality, this meant many nurses still were unwilling or unable to take the required time off to achieve that progression.

“It is still a female dominated profession - and my generation has worked right through from the beginning - that’s why you get burnout, or others stop and have families and feel they can’t justify the luxury of further study when they have children to bring up”

(Senior nurse in managerial role)

Instead, nurses would like more flexibility to develop as and when it suits them, with clearly organised channels for progression that would help them better plan their careers.

Many recognised that the investment this would require might be a barrier, now or in the future, but that this required new thinking on better use of resources, e.g. using what was already available in the healthcare world:

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“I’d consider opportunities for shared learning with other occupational groups - doctors, physios, pharmacists - there are certain aspects where it shouldn’t be separate pathways”

(Senior nurse in leadership role)

Giving nurses funded career breaks might be another way of ensuring wider access to higher levels of professional achievement -

“Or sabbaticals - taking a year out to research e.g. new ways of doing things. Possibly featured on a dedicated website or area of NHS website.”

(Senior nurse in clinical role)

Broader professional development options - in particular, promoting excellence in generalism as well as specialism as a career path

Many senior nurses and others discussed the need for training appropriate to a changing world, with e.g. an ageing population, advances in technology, etc. Here, the overriding theme was that of a holistic approach to patient management, which should allow any problem in any context, in acute or primary care, to be more efficiently dealt with.

In line with this, there was considerable discussion about the need to promote and develop generalism as a career path of equal importance and status as specialisation (see page 32), since it required very high skill levels and knowledge to take an holistic overview of patient care. Many pointed out that this was not an issue in medicine, where general practise is a very important specialism in its own right, further supporting the case for a parallel situation in nursing.

Enhancing the academic status of nursing

Several respondents identified the need to develop the disciplines (and funding) that are required to elevate the perceived academic status of nursing research to a level which matches other scientific disciplines in terms of prolificacy and originality.

This would be supported by recruitment policy designed to identify potential academics, as well as leaders and managers, and by an education system capable of developing their interests and contributions in this area.

Some also felt that there was an important future role for the RCN in supporting the academic aspirations of the profession and achieving wider recognition of nursing:

“They should consider splitting the RCN into a proper royal college that isn’t a trade union. At the moment they don’t have a royal college to try and drive standards. So an Academy of Nursing could be very helpful”

(Non-nursing professional)

5. Review performance evaluation to better reflect the new requirements of the unique role of nursing

If the vision of nursing as a holistic concept, comprising practical or technical expertise and emotional intelligence, is to be accepted and successfully implemented, it is logical that the whole picture of the delivery of patient care should be monitored and evaluated.

The concerns of many currently were that because the 'softer' values, which most closely related to the patient's experience were qualitative, and therefore harder to measure, they tended to be ignored.

"When I was managing community nursing, we had all sorts of performance indicators - very easily measured, clear clinical outcomes. But none on the softer aspects of nursing. We need to make people see it's equally important to develop both".

*"Current metrics actually reflect performance on a lot of measures which any healthcare worker could be delivering - I'd like to see more thought put into evaluating what **nurses** uniquely deliver - something around the holistic aspects of patient care"*
(Senior nurse in clinical role)

Clearly, the health service of the future, led by patient experience, needs to resolve this issue and ensure systems for measuring all aspects of patient care are in place.

Appendix

Methodology and sample for oral evidence gathering

Sixty nine individuals took part in the study. Thirty-two in-depth interviews were conducted by telephone or face to face during April, May and June 2008.

Interviews ranged from 10 to 90 minutes in length.

14 interviews were also conducted among members of the profession on Monday 28th April 2008 at the RCN Congress in Bournemouth.

In addition, two focus groups were conducted in May 2008 among nursing staff at two different hospital Trusts, comprising 11 and 12 respondents respectively.

Sample structure

| | |
|---|-----------|
| Healthcare leaders - non-nursing profession (e.g. chairs of Trusts or professional bodies, academic heads, senior practitioners in allied professions, etc.) | 18 |
| Nursing profession | 51 |

Nursing profession respondents by grade

| | |
|------------------------|----|
| Managerial/leadership | 17 |
| Senior/or retired | 13 |
| Junior/newly qualified | 7 |
| Student | 14 |
| TOTAL | 51 |

Nursing profession respondents by specialisation

| | |
|---------------------|----|
| Adult | 23 |
| Child | 10 |
| Mental Health | 11 |
| Learning Disability | 7 |
| TOTAL | 51 |

References:

1. Dawoud D, Maben J. *Nurses in society: starting the debate. Written evidence*. London: National Nursing Research Unit, King's College, London, 2008.
2. Department of Health. *Framing the Nursing and Midwifery Contribution: driving up the quality of care*. London: Department of Health, CNOs directorate, 2008.
3. Maben J, Griffiths P. *Nurses in Society: starting the debate* London: National Nursing Research Unit, King's College, London, 2008.