Too Posh to Wash?

Reflections on the Future of Nursing

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Edited by Gail Beer

With a Foreword by
Jeremy LeFroy MP
for Stafford

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Foreword

Jeremy LeFroy MP

The publication of the report of the public inquiry by Robert Francis QC into the Mid Staffordshire NHS Foundation Trust (MSFT) and why its failures were not picked up earlier by the wider NHS is a very important moment. A senior official at the Royal College of Physicians told me that it was the most important look at the NHS for at least twenty years.

The first Francis report, published in 2010, laid bare completely unacceptable levels of care within the Trust. These were not isolated incidents but the resulted of systemic failings and a culture in some parts of the Trust which had gone badly wrong.

MSFT was not the only place where these problems have arisen – Maidstone and Winterbourne View are two further examples– but the extent and period of the failure to care, particularly for the elderly and vulnerable, was shocking. It was only the brave and persistent work of Julie Bailey and others in the Cure the NHS group which persuaded the Healthcare Commission to investigate.

I hope that the publication of the Francis Inquiry report will lead to a transformation of attitudes in the NHS – putting patients and their safety and care at its heart. The report will undoubtedly highlight the failures of organisations and individuals – and they need to take responsibility for their actions, and not try to shift blame elsewhere. But the outcome of the Inquiry must be a better health and social care system, one which instils the highest levels of confidence and trust.

The Chief Nursing Officer for England, Jane Cummings, has called for more emphasis to be placed on nurses providing compassionate care in hospitals and that action 'must be taken to ensure that the values nurses stand for are not betrayed.'

This publication and its contributors explore some of the possible solutions and take a forward looking approach at nursing and its role in modern medicine, rather than looking back to a 'Golden Age' which may not always offer meaningful answers to the challenges which nurses face today.

It is striking to note how many contributors argue for greater compassion for the elderly. While we expect our nurses to offer compassion and respect for the frail elderly, we need to accept that clinical staff may reflect society's attitude more generally. Too often we ourselves undervalue older people.

Finally, it is vital that we remember that the vast majority of our nurses, doctors and others who care for us do an excellent job. By putting patients right at the heart centre of health service, we can support the professionals in their vocation.

About this publication

Nursing and nurses have been the subject of much criticism of late. The CQC has identified hospitals where respect, dignity and basic care have been woefully and dangerously neglected. The Francis report, when released, will demonstrate failings within the NHS and within nursing in particular, causing yet more anxiety for the public and patients as well as further eroding confidence in the sector. Similarly, we are presented with stories, and evidence, of neglect and abuse in care homes by untrained and poorly supervised staff.

Alarmingly, common themes seem to be a lack of compassion and respect and regard for dignity. Why is it acceptable to deny the sick, vulnerable and elderly the right to compassionate and high quality nursing care? What has gone wrong and how can we put it right before nursing and nurses lose the confidence and respect of those they care for and work with?

Many nurses are hard working and dedicated, and will be shocked and dismayed by the reports they read. We cannot solve this problem by creating a few new roles or ticking a box. A new and enlightened approach needs to be considered.

Through commissioning a number of articles from a range of practitioners and experts in the delivery of healthcare we have explored some of the issues nurses and nursing currently face. This includes, the future of nursing and nurse training, the cultural perspective and what nurses and their leadership need to do to respond to the changing and challenging healthcare environment.

We asked contributors to address a series of questions:

- Why do we have lapses in nursing care and what needs to be done to prevent poor care back into caring?

- In striving for professionalism have we over qualified yet undertrained today's nurse? Are they too posh to wash? What mechanisms and support systems need to be in place to 'bring excellence' back into the profession?

- Has the role of the nurse leader been devalued? Has respect for their knowledge and expertise and a desire to emulate them decreased?

- Why have boards within both NHS and non-NHS organisations appeared to have failed to deliver the expected improvements in quality of care? Are board members unaware of the standards on their wards or in their care settings?

We cannot recreate the nurse of yesteryear nor should we be looking back to a golden age of nursing, which may well not have existed. We must accept this fact and so contributors were asked to take a forward looking approach when addressing these issues. They were asked to present a range of ideas for the consideration of the leaders of our healthcare services.

Introduction

There can be no doubt that nursing is a vital, life saving and sustaining therapy which all of us will need at one time or another in our lives. This may be on a visit to the GP practice, a stay in hospital, through contact with mental health services or in our own homes.

The debate which has started, surrounds the quality of this nursing and who provides it. Registered nurses are in short supply. The increasing complexity of health care requires them to be educated to degree level. Moreover, registered Nurses are increasingly prescribing care for others to give. They often have to delegate some aspects of their role to assistants in order to ensure increasing numbers of frail, older people get the care they need. Yet recent events would suggest we should not be complacent about the care we and our loved ones receive.

We start with Deborah Sturdy from the International Centre for Longevity, who asks 'is nursing at it's watershed?'. Deborah, along with a number of contributors, makes the point that it is the elderly who are most at risk from poor standards of care and question if this represents sea change in our society or something we have hidden away for far too long. Julia Manning, Chief Executive, 2020health; Baroness Greengross; Deborah Sturdy, Trustee/Director, International Longevity Centre- UK; and Margit Physant, Policy Advisor - Health and Wellbeing, Carers UK; make these points and offer us some solutions.

The training and education of Registered Nurses is given plenty of coverage in our contributions. We often hear sweeping statements about the fact that part of the problem is that it is a requirement for nurses to obtain a degree to care for patients and many reference the 'good old days' when this was not necessary.

It is extraordinary that some may believe nurses are too well educated. The ability to seek out evidence for best treatments, to problem solve with knowledge and to work as an equal in the health care team, are all prerequisites for the solution to the negative perceptions of nursing we are addressing in this pamphlet. A theme which arises more than once in this short publication is the difficulty

front line staff, who are charged with teaching students clinical skills, have in being free enough to act as role models and teachers. The question that is often raised is, "are nurses too posh to wash?" when perhaps the question which should be asked is are nursing students given enough one to one teaching in the clinical areas to learn how to wash in the first place. Professor David Sine, Maura Buchanan, Independent Nursing & Healthcare Adviser, and Jenny Aston, Advanced Nurse Practitioner, address these issues thoughtfully. They make the point that we should not fear educated nurses, but embrace them. Justine Whittaker, Director and Nurse Consultant, reminds us that educated nurses will not always be compliant and will find a voice that may not always suit those in positions of power.

Following this, we turn to the systems in which nurses operate. Change is a daily occurrence within health and social care. This itself demands that employees are wide-awake, well educated professionals. The question is how much does the system work towards channelling nurse's time to care directly for their patients and teaching their students? How much do the demands of the system hold nurses back from doing what they are employed to do? One of the striking issues raised by patients and their carers is the varying quality of care they encounter when being cared for by different teams, in different wards or in the community. The evidence is clear- the ward sister, charge nurses and the community matron all set the tone and create the environment within which the team can thrive. This often means nurses have to fight the system if it holds them back from doing what ought to be done.

It also means demanding from nurses an absolute requirement to put patients first, leave their social lives in the staff room and ensure their appearance and personal grooming inspire admiration and confidence at all times. Very often their clinical competence is taken for granted by patients, but spoiled if delivered in a slip shod unprofessional manner. Lou Harkness-Hudson, Unit Manager, Clinical Assessment Unit Rochdale Infirmary; Rosemary Macalister-Smith, Healthcare Advisor (nursing, midwifery and regulation), Healthfit; and Samantha Walker, Executive Director, Research & Policy, Asthma UK; all make the point about good leadership being the key to improving standards. Gloria Dowling, Specialist Advisor to London Resilience Team (LRT), NHS London, however presents us with yet more challenges for nurses, as technology changes the systems they operate in. The challenge the health service faces is that the simple principles that are so important in nursing are hidden amongst a deluge of standards and regulations, which have grown over the past decade in response to the most recent scandal. As nurses are demanded to provide

evidence of compliance to these standards themselves, they are taken away from patients, and so the cycle begins again. Both Harry Cayton, Chief Executive, Professional Standards Authority for Health and Social Care, and Ann Farenden, National Professional Advisor, Care Quality Commission, demonstrate some of the difficulties in regulating care and explore what regulators need to do. Tony Caplin gives a view from the Board, which arguably is where the real action must now take place.

The answer to the questions we have posed is quite straightforward. The clinical teaching of nursing students needs to be resourced to allow mentors (those front line nurses who teach) to spend one to one time with their pupils without interruption. This will address the current theory/practice gap. These mentors need to be operating within a clinical team, which demonstrates the highest standards of care and behaviour to which students can aspire. One of the questions raised in this short pamphlet is this: How well trained are the assistants who are carrying out the delegated tasks? Those to who nurses delegate tasks that contribute to the overall prescription of nursing care should be properly trained to undertake those tasks and as importantly registered nurses should ensure the nursing assistants are properly supervised and supported. Gail Beer, Director of Operations, 2020health, attempts to give us a solution.

There is hope. Both Kay Fawcett, Chief Nurse, University Hospitals Birmingham NHS Foundation Trust, and June Andrews, Director of the Dementia Services Development Centre, University of Stirling, refer to intentional 'rounding' of patients providing order and method to care. The evidence is clear and simple and is being put into practice. If we combine this with time for teaching both those in training and unqualified nurses, a team culture of excellence and an explanation to patients, about who does what and why, the story begins to change. Yet it is not just nursing rounds which are receiving attention, the Medical Royal Colleges and the Royal College of Nursing have recently published guidance on the requirements for daily multidisciplinary ward rounds to be properly carried out to review and update care. Add to this the principles which have emerged in this short publication and we will soon move beyond the cheap headlines and counter comments to the real discussions about how we manage health in this country, because at this point in time we don't.

20/20 Vision - Nursing in Perspective

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Red and Yellow Care

Is this nursing's watershed? The current media battering and public disquiet about the profession of nursing appears to have hit an all time low. The Prime Minister's statement at the start of 2012 which appears to tell the profession how to behave and what to do should make us all sit up and question why that has happened and stir us to feel ashamed.

Nursing has changed and will continue to do so as we face increasing demands of a population which has reached seven billion globally and a demographic shift which means we are seeing a much sicker, frailer and older population in our daily practice. The demographic impact has been underestimated by the profession and we have not done enough to prepare the workforce with the requisite skills and knowledge to deal with it. Do nurses today really understand that they will be working with older patients across all clinical specialities of adult nursing? Cancer, surgery, intensive care and community services? I think not. Has this impacted on the attrition rates of nurses in training? Have we been honest about what the 21st century nursing agenda is?

The Cinderella 'geri' services of the 1980's and the 'geriatric wards' were places where the nurses who were perceived not to be able to hack it in acute services were banished. The underestimation of the skills and values needed to work with this complex older cohort of patients with multiple comorbidities, functional deficits, mental health needs in addition to their cancer, fracture, vascular surgery or myocardial infarction is palpable across services today.

Nurses have failed to grasp the full opportunity around the older patient. Nursing has created a plethora of new roles and 'specialisms' which should be applauded, but the generalist is needed too. This is evident in the older patients we see. The nurse in the Care Home who is seen as the 'lowest of the low" is far from it. The dependency of residents entering a care home in 2012 is much higher, they are much frailer and will have a multiplicity of nursing needs. A complex drug regimes and clinical interventions will be required. Long gone are the days of the residential home where relatively fit and independent people live and everyone played skittles in the afternoon.

The 24,000 Care Homes in the UK employ many registered nurses who are the forgotten workforce by their nursing family. The Care Home does not have machines that go bleep or the junior doctor who can be called from the ward next door. The dependency on out of hours services, GP locums and long waits for a visit mean that the nurse in the Care Home has to know what they are doing and there is often no other registered nurse in the building to even discuss a resident with. That is where nursing has retained its place as a profession with autonomy and huge responsibility.

Bring on the new roles, clinical skills development which enhance the nurse's ability to improve outcomes for patients or residents but we need to remember that nursing has its place at the table in equal measure to that of any other professional. It has to act in the professions best interest and not respond to the fiscal challenges without sound reason and good clinical judgement. Extending our roles can only stretch so far.

Nursing leadership has to be visible and it has to be vocal, we have lost that nationally, at board level and at the bedside in some places. The profession needs to hear what the public are saying, they need to take action to ensure the best for patients. Nursing has to be its own advocate, sharing the good, ensuring every day we challenge what is going on in our communities, hospitals and care homes. Not to challenge is to condone, it means we have failed in our duty. Nursing is, and should be, a profession of which we are proud and of which we really want to be associated with. How many of us can truly say we feel that every day?

We are at a tipping point and we have a chance to stop this toppling over into a great abyss. We have an ageing population, we need to prepare the workforce to meet the challenges of today but also of tomorrow. We will see considerable numbers of people with dementia coming into our care, and all the additional skills that will be needed to support that are grossly underestimated. We need to stand up and be counted, speak up and stand together. We can learn a lot from medics who seem to execute the maxim 'united we stand, divided we fall" with aplomb. Older people make up the majority of the NHS workload, the nurses banished to the 'geriatric wards' need to be unleashed and we all have much to learn from them if we are going to have the best for and by our patients. Cinderella has arrived at the ball.

Nursing in an ageing society

Margit Physant,
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The ageing population has implications for healthcare, and for nursing in particular. There are now more older people in society than ever before, they are more likely to be ill and admitted to hospital than others and they stay for longer. This means that caring for older people is a major part of the work of the NHS on most wards. Rather than just needing treatment for a single condition, older people are more likely to have complex needs as a result of underlying long-term conditions combined with the effects of ageing.

Dignity in care is essential. The quality of essential care has a profound effect on the lives of older people. Finding the right way to talk with an older patient and respond to their needs, wants and fears and treat them with respect, will help sustain and enhance that person's self-confidence, independence and determination to remain active.

On the other hand, poor care, even for a short time, can have a devastating impact. Older people describe how their skills and self-confidence deteriorate as a result of poor care, such as having things done to them rather than with them and being belittled by patronising language.

Poor treatment of older people does not happen in a vacuum; it is rooted in ageist attitudes in society. Older people are often described as a problem for care services and referred to as 'bed blockers'. In contrast, the contribution made by older people, for instance in volunteering or caring for relatives, is rarely acknowledged.

Dignity is a right. Awareness of ageism and its effects has increased in recent years and the introduction of age discrimination legislation in the Equality Act 2010 is recognition of this. The Act provides protection against discrimination, harassment or victimisation on grounds of age. It also introduces a duty on public bodies to eliminate discrimination, advance equality of opportunity and foster good relations between different groups. Public bodies will have to consider how their services affect older people and this will need to be reflected in nursing.

The NHS Constitution identifies several rights including the right to be treated with dignity and respect, in accordance with your human rights.

The National Institute for Health and Clinical Excellence (NICE) recently published clinical guidance and quality standards for patient experience in NHS services which include these standards:

• Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

• Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

The Care Quality Commission says that providers of health and social care who comply with its regulations will recognise the diversity, values and human rights of service users and uphold their privacy, dignity and independence.

A number of reports exposing severe shortcomings in the care of older people prompted Age UK, the NHS Confederation and the Local Government Association to establish the 'Commission on Dignity in Care for Older People' in July 2011. The aim of the Commission was to identify the underlying causes of poor care in hospitals and care homes and determine what must change.

The Commission gathered evidence and published the findings with a set of recommendations in February 2012. This report, 'Delivering Dignity', recommended fundamental changes to health and social care:

Dignity in care: should be central to the teaching and training for all health and social care staff. Selection processes must ensure that prospective students understand and embrace the idea that they will spend much of their time looking after older people. Education and training programmes must reinforce the provision of dignified care and should include an understanding of ageing, dementia and dying.

Getting the right staff: Looking after older people is not simply a matter of common sense and sympathy. On the contrary, an older patient is far more likely to be suffering from a range of conditions which require skilled nursing. However, technical competence is not enough. Hospitals should recruit staff to work with older people who have the compassionate values as well as the technical skills. Good care is everyone's responsibility: Person-centred care champions compassion and respect and puts the individual

at the heart of decisions. There is an imbalance of power in the relationship between a person receiving care and the staff providing it. Those who provide dignified care seek to redress this imbalance by involving the individual in decisions wherever possible, explaining what is happening, listening to and addressing concerns and, above all, treating each person with respect, empathy and kindness.

While existing 'dignity champions' perform an important role, everybody involved in the care of older people must feel personally responsible for championing dignified care. Professionally registered staff are required to challenge poor care and they should do so as soon as they see any shortcomings. This helps colleagues understand how their care can be improved.

Health care providers should see older people's families and friends as partners in care rather than as a nuisance. Working with families is not always easy as the stress of illness can tax even the most loving relationships. All this requires skilled, sensitive and empathetic support.

To achieve a major cultural shift in care, there is a need for empowered leadership on the ward as well as in the board room. The values of dignity must be consistently communicated throughout – by the board, managers, clinicians, team leaders and all staff.

Leadership and management: The leadership role of the ward sister or charge nurse is crucial. They should know they have authority over care standards, dignity and wellbeing on their ward, expect to be held accountable for it and take the action they deem necessary in the interest of patients. They should lead by example, helping other members of the team to deliver dignified care and challenging poor practice. In embedding values and behaviours around dignity, sisters and charge nurses should build on what is already being done correctly. They must ensure that every member of staff coming onto their ward understands the standards of care expected of them.

The commissions next step is to plan how these changes are made, for more information please visit www.nhsconfed.org/dignity

Unlocking Nursing's Potential

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The current changes we are seeing in the way in which Health and Social Care is being delivered gives rise to the need for professions to respond in creative and innovative ways. Nursing is well placed to do this if it desires to take up the challenge and place itself centre stage in delivering new solutions to the growing ageing population, and in particular the needs of those with dementia.

The move towards greater integration between health and social care will blur the boundaries and the profession will need to respond to different systems, values and cultures. Stepping out of the traditional health role and structures of hierarchy will cause discomfort and anxiety for many but for the few they will quickly see that the egalitarian opportunity of the changes for creating a system which will truly put people 'in charge' of their health and wellbeing. Personal health and care budgets will further empower individuals to make choices about how and where they receive their care. Creating a nursing response through entrepreneurial and innovative solutions could make a significant contribution to achieving this. Small independent practices of clinicians tailoring care to the individual rather than fitting into the confines of traditional structures provide ample opportunity for the brave. Nursing has an important role to play in the new emerging world and in particular in its response to the needs of frail older people. Nurses, as both advocates and pragmatists, will be well placed to deliver solutions based on need rather than available services.

With the estimated 750,000 people with dementia in the UK today nursing has a critical role to play in supporting people to live full and active lives. Supporting both the person with dementia and their families through investing in sustainable relationships through the life course of their dementia journey will enable real choice and control, provide advice, support and care to enable people to live and die in their own homes wherever possible and retain their dignity and relationships through to the end of life. A new hybrid of practitioners who can navigate complex systems and processes, translate the languages of health and social care and engineer outcomes driven by the individuals wishes would see a truly person centred approach to care.

Nursing has to place itself centre stage in the debate and ensure its creativity and drive, reminiscent of Florence Nightingale and her foundations of clinical practice, if it is to reach its potential and ensure its future. The fiscal, national and global challenge is a platform for radical ideas and opportunity to step away from the inertia of care practices. Never has there been a time such as now where the old adage 'when the going gets tough the tough get going' been true. Nursing through its history has been at the forefront of providing a critical role in the delivery of healthcare not only as a major staff group in the NHS, but before its inception too.

Nursing spans the generational boundaries and its influence on the population is immense from cradle to grave. The children of today are our older people of tomorrow. The role of the nurse in ill health prevention and promotion of well- being influences the shape of our society. The profession should not underestimate the impact it is having along the age spectrum. Nursing is a constant partner in the well-being of the nation and as we see the demographic challenge ahead, keeping the nation well and healthy across the ages will be necessary in contributing to the reduction in the demands for health and social care in future years.

The profession has to take the long view of its role in shaping our society, its opportunity to be enablers of choice and control rather than advocates and interventionists. Nursing needs all its creativity, leadership and vision to both recognise the critical role it plays today but also its imperative role in creating a healthier ageing population. Without stepping away and acknowledging where it has come from and the role the profession has played to date along with the acceptance of its responsibility and privilege in shaping the future, it will not reach its vast potential in being the driver of the change we need to see for sustainable care.

Regulating for compassion – the role of professional regulators in promoting compassionate care

Harry Cayton,
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The alleged absence of compassion in nursing care is a common theme in recent healthcare scandals, and is one of the themes of this book. In parallel, the importance of compassion is also stressed; as one paper put it, 'quality of care includes the quality of caring. This means how personal care is – the compassion, dignity and respect with which patients are treated' (Department of Health, 2010). The regulators of health professionals set the standards of conduct and behaviour which their registrants must demonstrate in their day to day work. Yet the task of articulating and explaining to registrants what is meant by compassionate care is difficult territory. Clearly, health professionals cannot 'suffer with' their 'suffering' patient – the literal meanings of compassion and patient. Such an effort of empathy would be both exhausting and distracting from the professional task in hand. Equally undesirable would be a lack of any emotional engagement; a glacial distance would be both obvious and repellent to most patients. How can regulators define an optimum state between the two extremes?

A further difficulty is that compassion implies an intimacy which sits uneasily with health professionals' obligations to preserve clear personal and sexual boundaries between themselves and their patients. While some patients welcome an openly compassionate and expressive approach, others do not wish to engage at this level with health professionals at all, preferring greater distance to be preserved. The challenge to professionals and their regulators is to explore the latitude involved – the extent to which they should amend their behaviour according to the individual before them and the ways in which they should be constant.

But these observations assume that professionals' compassion is a given; what if compassion is only sporadically present, or entirely absent? Can regulators promote compassion in the sense of instilling it where it is lacking? There is some research evidence that suggests that teaching or inducing compassion is possible. One study found that meditation could heighten activity in the area of the brain associated with compassion (Lutz et al,

2008). Other research found that working in an environment which is demonstrably compassionate and encourages students to pursue cases in which they become interested and involved encourages and promotes compassion (Pence, 1983).

However, what is evident from both studies is that inducing or eliciting compassion is no small undertaking. A more pragmatic approach for regulators would be to concern themselves with defining compassionate conduct, rather than trying to ensure and influence internal motivations. Conduct and behaviour can be measured, evaluated and assessed taking into account the circumstances in which it took place. Regulators can promote examples and guidance on what constitutes acceptably compassionate behaviour.

The next challenge is how regulators can convey their standards effectively to their registrants. How do they know that their guidance is changing behaviour for the better? A study that we commissioned in 2011(Quick, 2011) showed that little is known about the specific influence of regulators on the behaviour of their registrants. This is not to say that there is no influence, but that the nature and strength of the influence is an unknown quantity.

What is clear however is that individual professionals are subject to numerous influences on their behaviour, arising both from within themselves and in their working environment. Some of the most potent influences on behaviour are those which arise close to where they work – the teams and workplaces of everyday life. The study also highlighted the underuse of behavioural theory in understanding regulation's influence.

At the Professional Standards Authority we have begun to try to address the absence of knowledge in this area, in order to better understand how regulators can more effectively promote compassionate conduct, as well as the other standards they define. Building on the findings of the 2011 study, we are undertaking a further review to explore the potential of the behavioural sciences to help us understand how registrants relate to the standards that their regulators set, and what influences compliance.

By pursuing this line of enquiry, we hope to be able to promote new ways for regulators' standards to be communicated, received, processed, internalised and acted upon. This would be to the benefit of all; to patients, who would enjoy more consistent standards of compassionate conduct; to health professionals, through better and more effective engagement with their regulator; and to regulators, if it meant that less cases of alleged

unfitness to practise needed to be heard, the most expensive of the regulatory functions.

Finally, regulators also need to be wise enough to regulate with compassion; to treat regulated professionals with sensitivity and care, in particular those facing allegations of unfitness to practise. The daily pressures of work are stressful; much more so having your fitness to practise called into question, assessed, tested and possibly found wanting.

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More information about the work of the Professional Standards Authority can be found at
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A View from the Board

Tony Caplin,
Chairman, The North West London
Hospitals NHS Trust

A Trust Chairman has many responsibilities, none more important than assuring good patient care. Whatever else fails, nothing can be worse than a failure to look after our patients.

An NHS Hospital Chairman should see responsibility to patients as his or her first duty. It needs to be seen to be so by others and demonstrated over and over again. The chair needs to make sure this responsibility is in the actual bloodstream of the organisation.

The Trust I have the privilege of Chairing is by any standards very busy. Every single day, seven days a week we need to discharge 25% of our total bed capacity simply in order to stand still. The Trust works too close to 100% of capacity, a challenge by any standards.

Like most Chairs I am neither a clinician nor an expert in hospital administration. Worse, I am very part time and depend heavily on the excellent professional executive team. Key in the team is the Chief Nurse, because key to good patient care is leadership; the role of the Chief Nurse can and should make a big difference. This post is critical to any organisation which delivers care to patients. The Chief Nurse cannot take on this role alone. I have habitually made a nuisance of myself by walking into a ward or A&E at different times of the day without notice. I make a point of saying hello to all the staff, I deliberately look at cleanliness and how tidy the ward is. I also make the clearly visible point of asking a patient if they are being treated well. I encourage my non executives to do the same in an orderly professional manner.

As a non professional it took a while to figure out what I was looking for in the 'very best'. I think dignity stands out as the key word. A good nurse affords dignity to the patient, showing real interest, empathy and compassion. Dignity should reduce suffering, enable the patient to recover quicker where possible, and feel safe.

A busy hospital will have its share of complaints, a busy inner city hospital more so. It is vital complaints are dealt with quickly and in accordance with procedure and practice. There are numerous reasons why a patient or loved one will write a complaint. The truth is, too many are genuine, and demonstrate shortcomings in the system. The truth is, our hospitals are too busy; the desire to meet targets and budgets constantly a threat. The danger that this could get worse is threatening high standards of patient care.

We have tried hard to encourage a no blame culture throughout our hospital. Better we learn from mistakes than knee jerk into blame. Although I believe this has much improved the environment, I have been too often saddened by examples where we have let ourselves and our patients down. I have learnt to realise the enormous good done by the body of the nursing staff and I have also learned how difficult the nursing job is. It is a human system, and human beings are not perfect. Mistakes happen, we all get tired, overworked and do work in high stress situations.

To further improve our care we commission professional neutral advisors to interview and video patients once they have left us to share their experiences as a patient - good, bad and indifferent. We continually learn from this process as these independent professionals tease out the truth. We then play back the video to the nursing staff in select groups to enable them to learn. This activity has had a material beneficial impact on individuals as well as the body of the Trust. We also play selected videos to the board.

Our Board takes a real interest in the work of our nurses. Every Board meeting we invite three Matrons to share with us their anxieties, plans for the future and real life examples of recent improvements. In addition every quarter we invite a patient to come and address us on their experience, good or bad, and what they think we should be doing.

Our Trust pioneered the 'we care' programme, now adopted by many other Trusts in the UK. I am proud of the nurses in our Trust; they have continually made improvements in a difficult environment. We recognise that good nursing is essential to good outcomes, but nurses need to be supported in their work. Looking back, Boards could be faulted for not spending enough time understanding the role of the nurse, and importantly their wellbeing. Boards need to find more ways to demonstrate the value they place on nurses and the contribution they make.

Future of Nursing – The CQC perspective

Ann Farenden,
National Professional Advisor,
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Nurses play a pivotal role in the delivery of health care today. Our responsibility at CQC is to regulate health and social care across England and monitor whether providers are complying with the Essential Standards of Quality and Safety (CQC 2010). In the course of our work we see standards of care provided by nurses that go across the spectrum from high quality, safe care to poor quality, unsafe care.

There are many examples of good quality care in which nurses engage positively with patients, by providing encouragement, reassurance, and by being attentive to each individual's needs. They give patients information they need to make choices, take account of their preferences for diet, form of address and meeting hygiene needs. They explain care and are readily available to answer questions. They undertake risk assessments for developing pressure ulcers, falls and malnourishment and provide care to address individuals' needs. In addition they audit the care they provide and take action to make improvements. Such examples can be found in all sectors where nurse care is delivered.

Recent inspections have also highlighted aspects of poor care provided by nurses, such as patients not being given any information when they arrive at hospital and having to make their own discharge arrangements as no-one spoke to them about their needs. Other examples include patients' care needs not being met, not getting help with eating or drinking or having the opportunity to wash their hands before eating meals as well as their records being inadequately completed. There are also examples of staff not following their own policies on hand hygiene and ensuring that the environment for care was clean and free from hazards.

There are many factors that influence the quality and safety of nursing care. In all the investigations and many reviews and inspections CQC have undertaken so far, issues around leadership, staffing levels, education, training, supervision and appraisal have all presented as factors underpinning the compliance with regulatory requirements. Having insufficient numbers of nurses, with the right training, on duty can lead to poor care. In the review of dignity and nutrition (CQC 2011) we found that in half of the non compliant hospitals, inadequate staffing levels and lack of training were common factors. We have also found that when there are not enough nurses to deliver the level of care required they have to prioritise care and they may not have time to get people out of bed or have time to talk to relatives and tend to needs promptly. Patients may also be at greater risk of falling when they cannot be adequately supervised. Most nurses will be disturbed and upset by such events but will also understand that they need to be addressed.

Poor and ineffective leadership has also been present when failings have been found. This results in nurses being unclear of what is expected of them. They lack understanding of their roles and responsibilities. There is often poor team working, ineffective relationships and low expectations about what they can achieve for patients. Sometimes there is a culture of impotence and complacency with a reluctance to raise concerns about standards for fear they will be ignored or reprimanded. They are unwilling to report incidents and there is therefore little learning about how to improve.

Compliance with the essential standards of quality and safety requires sufficient numbers of nurses with the appropriate qualifications, skills, knowledge and experience to do the job and they must be up to date with current practice. They should be able to understand the physical, emotional and communication needs of the patients in their care, be able to respond to their changing needs and know when to seek more expert advice.

In order to be competent to carry out safe and effective care nurses must understand what is expected of them and have the right support in terms of training, professional development, supervision and appraisal. They also require clear standards and policies to guide their practice. The work environment needs to provide an open culture in which staff feel supported and are comfortable to raise concerns and know that these will be addressed. In addition, they must have access to properly maintained and suitable equipment and be adequately trained in its use.

Strong and effective nurse leaders at all levels are critical to achieving improvements in nursing care in the future. They need to foster a culture where patients are the priority and where everyone is alert to potential risks and harm; where abuse is not tolerated; where learning from mistakes is the norm and where people are confident that when raising concerns they will be listened to and action taken. They need to ensure that systems are in place to ensure safe care and that they are universally adopted,

such as standards for good practice, processes for assessing risk, for raising concerns, investigating incidents and taking action, monitoring actions debriefing staff and learning lessons. Nurse leaders should also support their staff in continual growth and ensure they have opportunities to develop and keep up to date and be supported supervised and appraised. In addition, they should facilitate effective team working and partnership. They also need to ensure that they measure and monitor performance by making use of the information that is available to make improvements which last. However, in order to be successful there must be ongoing investment in nurse leadership development, together with support to do the role and a manageable portfolio of work. Further, the culture should be such, that it will enable leaders to develop the confidence to use their initiative and be innovative in their practice.

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Preparing the Next Generation of Nurses for Excellence and for the Reality of Employment

Professor David Sines CBE,
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In 1959 Isabel Menzies Lyth produced her classic paper "The functioning of social systems as a defence against anxiety". This paper examined reasons for the poor retention rates of student nurses in a London hospital. It laid the foundation for work which attempts to look at the unconscious life of an organisation. Her work remains as significant today as it did fifty years ago and reminds us of the need to co-create dynamic learning environments that transcend clinical practice and academic preparation that takes place in UK universities.

If we are to instil a genuine passion for excellence amongst our student nurses then our aim must be to connect students with the reality of patient experience, aligned to the very best models and systems of evidence-based care and clinical interventions that combine the delivery of intelligent care with compassion. This journey must commence with early exposure to care 'in vivo', enabling patients and carers to share their 'lived' experience with novitiate student nurses who are welcomed into the clinical care team as valued colleagues, who will represent the next generation of professional care providers.

Such exposure from an early stage of a student's career can be challenging to all concerned but providing the opportunity to enable students to experience different care perspectives and treatment modalities in a safe environment will lead to the earlier acquisition of key interactional and clinical skills, confidence and capability. It is also essential that as individuals responsible for the safety and wellbeing of patients/clients and others in the healthcare environment, that our students understand and comply with the standards and values of their future profession. They will be required to demonstrate the achievement of practice and theoretical learning outcomes, but also provide evidence that they are professionally suitable for their chosen career through their conduct, behaviour and human interaction with patients, carers and members of the healthcare team.

As clinical leaders and clinical academics our mutual aim must therefore be to prepare the next generation of nurses who are capable and confident to provide high quality care for all and to ensure that our nurses are innovative, dynamic, capable and proficient in all that they do. They will need to maximise the nursing contribution to promote positive health and wellbeing to diverse and wide-ranging groups within their local populations, including those who present with longer term conditions. Above all they must provide intelligent care, underpinned by research evidence and compassion, at all times promoting the welfare and safety of their patients without compromise to clinical standards. They must also demonstrate willingness to challenge unacceptable variations in care standards and to enhance their skills and knowledge. This must be part of a commitment to 'future proof' the sustainability of the health service they assist to provide.

If nursing as a profession is to step up to these challenges then we will need to:

- prepare the future nursing workforce for the demands that will be imposed upon it for transition to a 21st Century patient group, employer and commissioner;

- build employability into our curricula from the outset to enable our students to be associated with their future employers as valued and integral members of the future workforce and in so doing expose them and socialise them to the realities of practice and the tenets of professionalism;

- ensure that our students are 'future-proofed' at the point of entry to the workforce, confident, competent and capable to take up their place immediately as qualified nurses and able to adapt their skills and practice as the employing organization changes and responds to external demands;

- produce autonomous, expert, evidence-based adult nursing practitioners who are capable of assisting our commissioners to design and co-deliver world class clinical services, in accordance with the vision, aims and objectives of the new NHS;

- instil a quest for non-aversive practice that develops practitioners who are fit to practice and capable of assessing and managing calculated risks in accordance with our NMC and provider Trust's requisite standards;

- embed research, critical thinking and innovation both within the theory and practice components of our learning experience, supported by the production of effective metrics to measure success and effectiveness;

- develop dynamic placement opportunities for students that expose and challenge them to confront the complexity of health and social care, within, between and across clinical care pathways, supported by a curriculum that is 'wrapped around the patient's/user's real experience and journey';

- develop robust, enhanced and effective mentorship and preceptorship partnerships with our Trusts;

- celebrate diversity and promote equality of opportunity, responding always in an appropriate and adaptable manner to meet the diverse needs of our local patient populations; as such our nurses should be equipped to demonstrate cultural competence and cultural awareness.

Above all our next generation workforce requires access to expert mentorship and role models to nurture and inculcate excellence in practice and resilience in attitude to deliver optimal standards of care at all times, turning each patient encounter into a learning opportunity that leads to sustainable excellence. This approach will provide our nursing students with an insight into the dynamics of health care delivery and will encourage them to acquire an aptitude for creativity and innovation, always placing the patient at the heart of their agenda.

Have we overqualified yet undertrained today's nurses?

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Past President, Royal College of Nursing

Major criticism of nursing and nurses has come from a variety of sources, from CQC inspections, enquiries such as that undertaken into Mid-Staffordshire, the Patients' Association and from patients and relatives themselves. Such wide ranging criticism cannot be dismissed as a few unfortunate experiences in a busy pressurised service, nor down to a few 'bad apples' that have let the service down in the way they have treated vulnerable patients.

That the nurses of today are accused of lacking in compassion or failing to deliver dignified care should be a matter of grave concern to all of us in the profession. Whether or not these criticisms are justified, the public perception of nursing is being shaped by these reports.

The criticism of nursing is often targeted at nurse education as if to educate nurses, was somehow to reduce their ability, or desire, to deliver compassionate and dignified care. At this time when the profession is moving to all graduate entry by 2013 we need to reassure patients, public and the politicians that nurse education is not only compatible with caring, compassionate and safe practice but is it's very foundation.

Our patients surely deserve well educated, informed and competent nurses who can assimilate complex information and make safe and effective interventions. To suggest otherwise would be to fail to recognise the complexity of decision making that is necessary for safe care in today's healthcare environment.

It is not too many years ago that third year student nurses would be left in charge of wards at night. Today, with the complexity of surgical intervention and acuity of patients, this would be unimaginable, placing patients at risk and, indeed, could be considered negligent. Health care is an ever changing world and nurses need education that prepares them for the changes and challenges ahead.

Yet, preparing nurses to become caring, competent practitioners requires much more than the acquisition of knowledge and skills gained through the formal years of education. It is the application of knowledge and the development of skills over years of practice in a supportive healthcare environment that leads to truly competent nurses.

The visible demonstration of nursing is to be found at the interface with patient, be that at the bedside, nursing home or elsewhere. Perhaps that is where the problem lies, in that insufficient attention has been paid to the application of knowledge and skills at the point of care. It is not sufficient to demonstrate clinical or technical knowledge and skills, but the ability to respond to a patient with dignity, respect, compassion and good communication are equally, if not more, important. These skills take time to develop and require good mentorship, good role models and exposure to a range of situations where learning can be applied and practice advanced.

I would argue that the main responsibility for failing standards lies not with nurse education, rather, with the clinical practice environment for which employers must take blame. Over the years, as RCN President, I listened to students from across the country complain about inadequate or poor clinical placements. It takes time to properly support and mentor students throughout a clinical placement. Yet, nowhere have I witnessed managers taking account of the increasing impact of students on workload when setting the ward establishments. In these times of financial constraint, low staffing levels, high levels of temporary staff and reduced skill mix, failing to provide a high quality learning experience for nursing students can have a disastrous effect.

The failures in the learning environment do not just occur in the undergraduate/pre-registration years but extend into the early years post registration. No other healthcare profession is expected to 'hit the ground running' in the way that is expected of newly qualified nurses. Midwives, for example, have a required period of supervised practice, immediately following registration, and doctors have very structured learning and supervision over their early careers. Whilst the NMC might well advise on a period of preceptorship for new registrants, there is no requirement for such a programme to be put in place by employers. For some newly qualified nurses, a week or two supernumerary practice is the extent of their preceptorship, before being expected to take on a caseload of patients, often with little or no supervision.

A further consideration must be given to the significant proportion of nurses working in healthcare who originate from countries outside the UK. Provided their educational

qualifications meet the standard for NMC registration or they undertake an appropriate period of adaption, they are registered and free to practice. Their practice may be clinically sound but some may have little knowledge of the cultural and social aspects of nursing in this country leaving them vulnerable to criticism and lapses in practice. In some other countries personal care, including feeding, is delivered by families, not nurses. The nurse's main responsibility is to give out medicines and record clinical observations in accordance with medical directions. Again, there is a failure by employers here to provide proper induction programmes and mentorship to support cultural adaptation and understanding of the social context of care.

Nursing in today's health care environment requires much more than proficiency in a set of tasks. Nurses now need to be able to assimilate information and make decisions in increasingly complex situations. This requires a sound educational base and experience in applying knowledge and skills to new and challenging circumstances. It is a continuous learning process.

In addressing a conference of military nurses a couple of years ago, a question arose about nursing as an all graduate profession. I was impressed by a statement from one of their leaders that 'We train for certainty and educate for uncertainty'. How true is that comment when applied to the world in which nurses have to practice, now and in the future.

We do not train nurses; rather, we educate them for the increasingly complex and changing world of health care. But, we must never forget that nursing is much more than the application of clinical skills and knowledge, it requires caring compassionate practitioners to deliver the safe dignified care that our patients deserve.

Rethinking the role of the non qualified nurse

Gail Beer,
Director of Operations, 2020health

We often hear that it was all much better before nurses got degrees, and that if we went back to the way things were, care and standards would be better. Successive governments have come up with gimmicks to try and reassure the public. First, we had modern matrons then hourly patient checks. However, central dictates of this calibre will not do. More qualified nurses are unaffordable and are in short supply and in some circumstances may well be unnecessary. Is it time for us to rethink the role of the unqualified nurse and, more generally, what it means to nurse? Do we really know what we want or need from the qualified nurse?

In the 'good old days' it was simple, but today with so many complex treatments and technologies, and complex packages of care, the role of the qualified nurse has changed beyond recognition. The work that RNs used to do is now undertaken by unqualified staff. Yet the public expects nurses to take on the complex tasks and carry on doing what they always did. We then blame registered nurses for failing to supervise unqualified nurses, blame the unqualified nurse for delivering poor care, and blame managers for trying to get staff on the cheap by using unqualified nurses. Yet there is no real appetite for increasing taxes to pay for more nurses; it is time for a radical rethink.

What is it we really want from nurses and what do we mean by nursing? These are fundamental questions that cannot be answered in this short piece. What we do know is that increasingly, care will be delivered by unregistered staff and it is to their training and supervision, and regulation we must look if we are to assure high standards of care and restore public confidence.

Registration in this country will require a first degree; many of those wishing, and with a genuine aptitude, to take on caring roles will not meet the educational entry requirements. If action is not taken, society may be deprived of the skills and compassion of people who are not academically wired, or who are not willing to undertake university training. That is not to say that we should abandon the concept of a first degree for qualified nurses, it is very necessary and right. This is something we need to help the public understand.

If we accept this premise, how do we regulate and train those supporting the qualified nurse? Unqualified nurses, or what are really nursing assistants, and carers take on an enormous amount of work. They look after the physical, mental and emotional needs of patients and clients, allowing the qualified nurse to use his or her skills to carry out more complex tasks. Unqualified nurses care in diverse settings; within the NHS, in both acute and primary care, the private sector, and especially in social care settings. They care for patients and clients across a broad spectrum of ages, social backgrounds and physical conditions, all with varying needs. Without them many would be denied even the basic level of care.

The change in the way we deliver healthcare using ever more sophisticated treatments and technology will require the registered nurse to become a different kind of practitioner, highly skilled technically, but also a first class navigator through the complexities of treatment, as well as an informed guide on the choices that patients and clients will need to make. The nurse will become more than a prescriber of care, he or she who will not only evaluate their own practice but supervise and monitor the effectiveness of other nurses and deliverers of care.

The debate over the ratio of qualified nurses to non qualified nurses will raise its head when the Francis report is released. There will be stories about needing more qualified nurses and in the case of Mid Staffs this may well be true. Yet the number of qualified or registered nurses per head of population in the UK is comparable with the US, Western Europe and the Antipodes. Yes, we need to ensure that we have the correct ratio and that qualified nurses have sufficient time to carry out the essential tasks they are trained for. Just as importantly, we must ensure that those who are unregistered and caring for people in hospitals, care homes or the clients own home are properly trained, adequately supervised and adequately supported. We must be able to assure the public that the standard of care provided meets the physical mental and emotional needs of the client group, provide confidence that the system can prevent lapses in care and manage poor performance, and in the worst cases prevent re-employment in a caring role, should a nursing assistant or carer prove to be unsafe. There is much in caring that does not require those trained to degree level to undertake, but their supervision and insights are essential to support the work of the registered nurse and vice versa.

Today it is possible to apply for a job in care home with no experience and an offer of 'on the job' training. The bulk of the care given outside acute hospitals is to vulnerable, frail and often elderly patients. Interestingly,

and quite properly, it is not possible to offer your services to care for a small child with this 'hit and miss', variable and sometimes nonexistent level of training. The elderly and frail have as much right to protection as the very young. So what needs to change if we are to become increasingly dependent on the unqualified nurse? How will we assure the public they are being cared for safely, that the unqualified nurse is working safely, is supported in their working environment and is aware of the expectations related to performance?

The question is not whether we should have more or less unqualified staff, but how do we train, supervise and regulate nursing assistants and carers. We do not want to create a system that is prohibitive in terms of cost or one that deters those wishing to care from coming forward. On the contrary the system needs to create an environment which encourages those who do not want to become or cannot become registered nurses to work in the care sector.

Some form of registration of unqualified nurses has often been discussed. It has many merits, but to date we are no further forward and naysayers point to the cost and regulatory burden. While the debate goes on we cannot stand by and do nothing, there are some easier wins.

It is time for the introduction of mandatory, nationally, structured and accredited training for all those working in a care environment. No longer would staff be unqualified, but accredited to work in specific areas, for example in mental health, acute or community care

Those providing training would be licensed in accordance with a mandatory framework. Licensed training organisations need not be from within the NHS or indeed universities. Here lies an opportunity for the private sector or an entrepreneurial group of nurses who can provide hands on support in clinical situations.

Accreditation for unqualified staff would be achieved through a yearlong assessed and examined course. This is a system that is in place in a number of European countries and is an approach used across the aviation industry. We should develop a structured national training programme that provides a national qualification. A national scheme would restore confidence to patients and carers but to qualified nurses too.

Entrants must demonstrate written, verbal, and numerical skills to a national standard and candidates be assessed as to aptitude and suitability though structured interviews. Sadly today it is possible to be accepted into nurse training without having an interview.

Employers should be charged with a mandatory role to recruit, train, supervise and manage staff according to the highest standards. They must assure themselves that there is no record of poor performance before employment is given. Their licence to provide care should be dependent on demonstrating they have the systems and processes in place that give the utmost assurance that the patients and clients are safe in their hands. Those commissioning health and social care must also assure themselves of the evidence they are presented with, and pay more than lip service to ongoing contract management be that in the NHS or outside. It must become more financially attractive to suppliers of care to provide excellence. If you don't then you lose the contract.

The question will be asked, isn't this all too expensive and unnecessary; a sledge hammer to crack a nut? More and more of us will be elderly, and more of us will require care of some kind. Increasingly this will fall to non-registered nurses and carers, not for financial reasons, but for the simple fact that many of us will not need the skills of the registered nurse.

Elderly and vulnerable members of society deserve a better system that provides them with the comfort of knowing the standards they should expect and that those carers who do not achieve the required level cannot care for others. The outcomes of poor care are often very expensive and it is a false economy not to invest in training our workforce to deliver high quality care.

Finally we should remind ourselves that there are some supurb non qualified nurses and carers out there, working now in somebody's home or by their bedside. They are much loved by their patients and clients and respected by their qualified colleagues. It is time to acknowledge the contribution they provide, demonstrate the value they bring by giving them the training and support they deserve.

What Future for Nursing and Nurses?

Jenny Aston,
Advanced Nurse Practitioner; Chair RCN
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Nursing has received very poor press recently and much of this is due to criticism of what are rightly seen as the basics of Nursing; respect, dignity and compassion. Our profession no longer appears to care in a way that was once seen as fundamental.

Compassion and vocation - the culture of Nursing.

The image of Nursing and nurses' place in society has radically changed over the last 30 years. Nursing is no longer seen as a vocation and is rarely a first career choice for school leavers. Those with A levels now have many more choices and the calibre of entrants appears to have dropped. Many students enter nursing after many years in other jobs and arrive with attitudes and behaviours which are hard to change. The portrayal of nurses in the media has done nursing a huge disservice. Hospital uniforms confuse patients by making it hard identify who is who. Patients used to know that sisters wore blue and doctors white coats. Modern materials tend to make uniforms look functional rather than smart and as a consequence nurses take less pride in their appearance. Nurses are also often seen in the street wearing uniform, which raises patient fears about cleanliness.

Nursing is no longer seen as a good job with prospects. 'Would-be' recruits are put off nursing by the lack of a career pathway, low pay and job uncertainty. Those who wanted to remain at a particular level such as Enrolled Nurses, were valued for providing a stable workforce. Today students entering nursing often have other responsibilities such as partners and children. Accommodation and travel to work, as well as surviving financially are more complicated than when most nurses stayed in hospital accommodation and walked to work.

Have we over qualified yet undertrained?

Greater emphasis is now placed on the academic learning of students. Whilst it is necessary to prepare students to manage increasingly complex medical conditions, it is also essential to teach the softer core nursing skills. There is sometimes too much focus on the knowledge rather than on attitudes and behaviours. With university based training, considerable responsibility is left with the placement mentor to ensure that students have the necessary hands-on nursing skills. Many students have minimal one-to-one learning from their clinical mentors, who are busy with their own responsibilities, and have little or no protected time to teach the essential skills. Trainee registered nurses now learn many of their skills and attitudes from unregistered Health Care Assistants (HCAs) whose training is hugely variable. In the past students learnt from more senior students, staff nurses and Clinical Teachers who worked with students on each placement. Clinical Teachers provided an invaluable link between the theoretical and practical skills and were able to assess student's competence as well as address any attitudes or behaviours which might need adjustment. University lecturers rarely have the time to visit, let alone work, in the clinical areas.

Good nursing involves carrying out a set of care tasks, assessing the patient as well as addressing the patient needs as a whole. One reason why patients feel uncared for is the fragmentation of care which has resulted from the delegation of tasks to HCAs. Although it may be sensible to delegate things like washing and feeding the result is that trained staff spend less time directly with patients, so subtle cues about a patient's condition may be missed. Trained staff are therefore increasingly reliant on second hand information about patients. In the past a significant percentage of the hands-on care would have been delivered by Registered, Enrolled nurses or students, in contrast today much of the 'nursing care' is done by HCAs. Continuing professional development beyond initial registration is a further concern, as funding and availability vary widely, leaving many nurses frustrated in developing their career. There is still much greater emphasis on hospital based training which is not a true reflection of the shift in healthcare. More consideration needs to be given to General Practice placements where students can gain a much broader understanding of health.

The role of the leader at local and national level

We live in a 24 hour 365 day culture, where expectations are higher and there is a greater emphasis on individual rights. Many of the criticisms directed at nursing reflect other changes in society. Patient turnover is faster, patients in hospital are sicker and more tests and treatments are available, alongside which patient expectations are higher and complaints and litigation are more common. Record keeping is by necessity an important part of patient care, but is often perceived by patients as 'nurses sitting at desks'. Perhaps time spent teaching record keeping and better use of technology could make the task more accurate and efficient.

Leaders at local level need to spend time on the ground to ensure they really understand the workforce, training

and resource issues. They need to be visible and approachable so staff feel valued and supported. They also need to be able to fight on behalf of the nurses to ensure that work environments are properly resourced, protected training time is facilitated and safe staff levels are maintained. High levels of stress and sickness are known to lead to demoralised and potentially unsafe practice. Clinical leaders in whatever area need to be encouraged and facilitated to influence decision making outside their own clinical area. An example of this is the work of the RCGP General Practice Foundation who are setting standards and competencies for Practice Nursing and seeking to establish sustainable national foundation training for all nurses seeking to work in General Practice.

Role of Boards and regulators in measuring and managing improvements in quality

There is a need for governance measures to be in place to ensure that care is of a high standard as there will always be a conflict between cost and quality. Board level decisions need to be based on a good understanding of how care can best be delivered and measured so on the ground clinicians need to be informing high level decision makers. Great care needs to be taken to measure the right things and not just numbers; otherwise real improvements will not be demonstrated. An experienced pair of nursing eyes and ears can identify good and bad care in a way that complex audits or form filling may fail to achieve.

Regulation is a necessary part of ensuring quality. Human nature dictates that we are more likely to stick to the rules if there are some to follow. Employers are much less likely to fund training staff to a certain standard if there is no requirement by a regulator to do so. External inspections by the CQC and other external bodies do make health organisations get their house in order. We have much to learn from our medical colleagues who now have a robust revalidation process to ensure that doctors can demonstrate ongoing competence in their speciality. Nursing needs to provide similar safeguards to ensure nurses maintain their skills. There are two groups (Advanced Nurse Practitioners and Health Care Assistants) who would benefit from better regulation to protect patients. HCA's need this because they are delivering so much of the 'nursing care' and therefore must be adequately trained. ANPs because they pose a risk to patients because of the level at which they work, assessing diagnosing, prescribing and referring.

What can be done?

We are currently in a vicious circle. Past decisions about recruitment, training, resourcing and supervision have led to a widespread deterioration in the respect that nurses show to patients and vice versa. It is down to leaders in nursing today to be better role models and close the gaps which have opened up in recruitment, training and management. Regulators need to rise to the challenge of ensuring quality and protecting the public. Finally, if compassion, communication and care were restored to the heart of nursing many of these issues could be resolved.

Fallen Angels?

Justine Whitaker,
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Nursing is often described as a 'vocation'. It appears that this has allowed some exploitation of the profession, giving others, particularly politicians, to form clichés. One can often hear terms like 'angels'. This term can be viewed two ways; firstly, most would think this OK if it is said by a patient, by way of thanks for some care which has been delivered and made them feel respected and treated with dignity. It can be viewed negatively, however, when it is used in the media or by politicians; as an example, one head line said 'Not all Nurses are Angels' when describing Mr Cameron's response to the CQC report, where five hospitals failed to meet basic standards of care to their patient. It is here that the term angels can cause offence to those within the profession and upset patients who use the term with the best of intentions. I neither agree nor disagree that nurses are angels as there is good and bad in all things; however the way society and the media uses analogies can be destructive.

However, for as many years as there has been news, the Nursing Profession has heard only how good and wonderful it is. So, in early January 2012 it was a shock to the profession, and the nation, to hear the Prime Minister criticise nursing.

There is no doubt that the nursing profession has taken a battering recently from many sources. Being told your good or constantly referred to as an 'Angel' has diminished the ability to deal with criticism, which in turn has an effect on confidence. Providing a platform for nurses to regain confidence requires a faceted approach. Education is an ideal platform for this. Bringing the Nursing Profession to graduate level has indeed created much debate. This should be embraced as empowering the nurses of the future with knowledge and courage to 'challenge' and 'critique' can only drive the profession forward. However, this can only be achieved if we invest in allowing the natural innate drive to care to be regarded at the same level as that which drives other respected professionals.

But Mr Cameron, don't be surprised that when you educate a nurse, that she won't occasionally 'ruffle her feathers'.

Changing times, changing expectations

Monica Fletcher,
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The Athenaeum

No self-respecting individual will get up in the morning and go to work to have an intentionally 'bad day at the office' be they a lawyer, teacher, banker (even!) or a doctor, and nurses are no different. Most people strive to do a good, if not an excellent job whatever their role. Yet if we were to believe the media headlines and general negativity reported in the press, one might be led to believe that modern day nurses are somehow different to everyone else and have some perverted pleasure in being, cold, callous and uncaring towards their patients and relatives. I simply do not believe this is true. So what is happening to the much maligned profession?

Firstly, the context in which nursing is delivered has changed, almost beyond recognition, and I do not think it is useful for 'mature nurses' like me, or commissioners or managers or politicians, to hark back (with misplaced sentiment) to the good old days and to 'how much better it used to be only a decade or two ago'.

So what is happening? Well, firstly I believe society as a whole has become less caring, maybe not intentionally, but due the fast pace and the 'here and now' culture. Neighbourliness no longer seems to exist and individual priorities seem to have changed with the priority being self rather than community. I recently had to stand on a train journey from London to Bicester, nothing unusual many commuters would say, but I was in a plaster cast, on crutches, following surgery and not a soul offered to give up a seat. We are talking about basic care and respect for each other as human beings. Have our expectations of how we expect to be treated and therefore how we treat others changed? Maybe we have too high expectations of nurses? The public expect nurses to behave in a way that no longer reflects the values of society itself. Possibly relatives no longer look after their own families as they once did but expect 'the services' to do it for them, and because of their guilt they are quicker to criticise nurses and behave with hostility when things go wrong.

Are low expectations of nursing care a self-fulfilling prophesy? So rather than believing nurses will be kind and considerate, are patients and relatives now expecting to have a poor experience in hospital, and as a result that is what they end up receiving. Do nurse lack self-efficacy and belief that they can now strive to offer excellence?

We need to reflect on how different the world in hospital now is. The case mix of patients who inhabit our hospital beds has changed beyond recognition, as has how they are managed. Those admitted with medical conditions – tend to have long term problems and mixed pathology; they are generally cared for by specialist medical teams; they are much sicker (as primary care services have absorbed more and more and have pressure to keep patients out of hospital), they are older (as we all live longer), and many experience psycho-social issues. Surgical patients are 'in and out' of hospital as quickly as possible, with the pressures on the NHS to improve efficiency. Hence rehabilitation occurs at home; many are admitted as day cases and most are discharged within 2-3 days. Long gone are the days when patients stayed in hospital until their sutures were removed and they were up on their feet. The drive to discharge patients within as short a time as possible means throughput has increased and therefore the demands on nurses has also increased. The luxury of caring for patients who were able to walk around the ward and indeed could help by serving tea to other patients in the 'dayroom' nowadays seems like 'dream world'. As soon as patients can 'walk' they are whisked away to discharge units and their beds are filled!

Many so called failures by nurses are reported to be systems failures or situational issues; nurses don't mean to starve or neglect the patients, they don't mean to be rude or not communicate with their patients, they are just too busy to spend time on the basics. Be that because of staff shortages, lack of continuity of care, increasingly high demand patients with complex needs, greater technology or more complex procedures for nurses to deal with. Increased technology may be hampering basic nursing, it may be that there a trade-off between the technological approaches to nursing and old fashioned caring. The question needs to be asked however in the 'old days' how many seriously ill or deteriorating patients were missed whilst nurses were making tea and toast and having a chat elsewhere on the ward. The challenge is to maintain the growth of technical skills and still be able to care.

With all these demands on nurses, at the same time we send relatives away at the very time that we need their help to care - mealtimes! Families are deemed a nuisance which makes them suspicious and more questioning about the care. They need to be part of the care supported by nurses and for goodness sake, they mustn't be early for visiting or bringing in flowers!

My formative years as a student nurse were spent under what I then thought was the tyranny of a 'ward sister' who ruled the ward with a rod of iron: god forbid if our patients weren't out of bed for breakfast and their beds weren't made before doctors starting coming onto the ward (no laissez-faire patient choice). What about the 'hospital corners' or the bed wheels being out of alignment? At the time, much of this seemed futile, but those role models were some of the best and most professional nurses I have ever known. Little did we know at the time that we were not just making beds, we were observing and talking to our patients and more importantly developing relationships with them, spending 'hidden' quality time with them. As a junior nurse I learnt so much, working alongside experienced colleagues as we undertook our duties together. However, now so much of the basic bedside care is undertaken by health care assistants, where is the bedside nursing leadership, our role models? Sadly many of them are no longer directly caring for patients; they are managing the ward and sorting out systems, sitting in meetings or indeed dealing with complaints from relatives about the care on their wards!

Nurses were once very low down in the hierarchy of health care professionals and have over the years striven for recognition. The profession has fought a battle for academic recognition moving from certificate, degree to master level education. What has this done to the expectations about nurses from patients, doctors and by us, as a profession? I do not believe it is because nurses enter wards with degree level training that they are too educated to care, they just have competing demands and expectations from everyone as a result.

Much of the recent criticism of the nursing profession has emerged from care delivered in institutions, predominately secondary care and care homes. Secondary care nurses are in particular much more exposed to the spiralling litigious culture which pervades the NHS Community and primary care nurses seem so far to have escaped the barrage of complaints and criticisms, possibly patients are less likely to complain in their own homes or when they are ambulatory or it could be postulated that this reflects the different focus of the range of scenarios with the latter groups, or that nurses have more time for the personal care outside institutions.

Courtesy and respect is what most of us want and expect from our fellow human beings and when we are feeling unwell or incapacitated we are even more vulnerable. I find it too hard to swallow that the care has gone out of nursing. As someone who trained as a nurse and has kept the 'nurse within me' throughout my multifaceted career, and in my personal life, I believe caring is what nursing is all about. It is not something you 'just do at work' it is a way of life and we may have to work much harder at getting this ethos back into our lives as well as into nursing or it may be that this has been lost forever.

What future for Nursing and Nurses?

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Nursing is based in a complex healthcare system where compassion and dignity are an expectation. Constantly discussed in the media, the suggestion that nurses are "too posh to wash" or "too clever to care" is never far away. So why is it that nurses have become the fallen angels of the care world?

Numerous high profile reports have cited cases of poor nursing care within the last 5 years and without exception they focus upon the inability of nurses to provide compassionate care.

Progress in health care has seen patient length of stay shorten, meaning that the need for effective communication has never been greater. The patient/nurse relationship is vital to ensure that care is individualised, appropriate and timely. As the operational tempo of care has increased, the relationship between nurse and patient has become more difficult to achieve, nurses work less days and longer shifts, making continuity harder to maintain. However, nurses remain the 24 hour workforce and through rectification of their roles in delivering continuity of care, nurses will be re-energized in the public psyche.

Compassionate care comes from a variety of sources, an individual's values to provide care to others, education and role models during a student nurse's three years of training and vision and values of the leaders of the organisation and wards and departments in which nurses practice. Should any one of these things be missing, then the delivery of such care is almost impossible.

In the future nursing must focus upon the selection of the right people at the right time with the right skills. A graduate nurse who does not recognise the importance of an individual's dignity is worthless in a society that will see an unprecedented rise in the older population and many people living, debilitated and dependent upon care, well into their 90s.

Once registered, nurses must recognise their responsibilities to continue to deliver hands on care, act as role models and assure themselves that the tasks they have delegated are delivered to the high standard they expect for their own loved ones. Finally at Board level, there needs to be a recognition that the focus for nursing should be on providing the best care.

Educational institutions which select nurses need to do so focused not only on their academic qualifications or ability to critically analyse care, but on the ability to communicate and recognise discomfort in another human being. More must be done to expose students to patients with communication problems and to the so called "challenging patient" who requires careful communication and sensitive care delivery.

Student nurses should feel part of care from the beginning of their education, and the ability to deliver the physical and psychological elements of care should be deciding factors in allowing them to become registrants. They should feel that they belong within an institution, be that an acute hospital or a primary care setting. Moreover these institutions should feel an ownership and sense of responsibility for teaching students the right skills. In order to achieve this Nursing should be a truly integrated professional training and educational experience and should be jointly owned by health care and academic institutions.

Care is complex, and the recognition of this is often limited to things that can be measured in dashboards and via formulae. These are reflections of the technical nature of care and can be taught, audited and reported on, but these interventions are not the only key to the delivery of care in 2020. Care in the future must utilise these valuable and increasingly complex tools to support thoughtful care, care which is delivered with humanity and not by rote. To do this nurses need to see the people that they care for, not as complex diagnoses, but as the people they once were and therefore still are.

When care rounds were introduced within this organisation in 2011, it was not just because the environment, designed with a public that has space and privacy in mind, prevented the observation of increasingly dependent patients. They were to encourage nurses to interact with patients. Sadly this was something which was increasingly lost within the busy wards and departments of hospitals. As the clinical areas became busier, communication with patients, the very thing which made patients feel safe and part of their care, became more limited.

Nurses had begun to move towards communicating with patients only at the point of intervention. Patients described isolation and a lack of people to discuss their worries and fears with. Care rounds enable patients and

nurses to regain the relationship that maintains continuity of care. Carried out properly they create an opportunity for nurses to engage patients and their families, share information about their care and encourage questions.

It is vital that the leaders of nursing, including Senior Sisters and Charge Nurses, recognise the importance of being a role model, demonstrate a commitment to effective communication, regular review of each patient and challenge nurses who care by habit or by rote. These leaders are the key to excellent nursing care and where they are found wanting, care will deteriorate.

In short, nursing must move with the times, learn to do things efficiently, effectively and in less time than nurses before them. In doing so they should not leave behind the things that make nursing about care.

This is not about stopping progress, for instance, education does not prevent nurses from being excellent care givers, it helps them to review their care and enables them to do a better job. Training and access to role models is essential to developing the skills that make that care about people rather than about tasks. Leadership ensures that these skills are maintained and taught effectively to new nurses and to the rest of the workforce.

Above all, supporting well selected individuals to do the right job, in an environment that shares responsibility for teaching the staff to deliver the best care they can, to people and not to conditions, is what will take nursing and nurses forward into the future.

Letting Leaders Lead

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The current culture in nursing is borne from a "can't do" attitude which is compounded by a lack of innovative and visionary leadership. As a consequence, an innocuous lethargy has settled over the NHS, leading to disillusionment amongst nurses and a lacklustre approach to change.

Nurses are often not involved in the changes that have to be made on the shop floor and this leads to them feeling devalued. In turn this leads to resentments which can pre occupy members of the team leaving little time left to invest in the care they deliver to the patients they are charged with looking after. This creates an enormous amount of inappropriately channelled energy which I feel could be harnessed and used to making change effective which can be exemplified by the success of the CAU in my hospital.

The CAU is the only unit of its kind in the country. It is successful because everyone in the team has had a hand in making it so. It was borne from the Healthy Futures reconfiguration plan, which was introduced 12 months prior to its original planned date due to medical staff recruitment issues at Rochdale A&E, therefore necessitating its downgrade to an Urgent Care Centre (UCC). Linked to this was the reconfiguration of the 32 bed Medical Emergency Unit, resulting in the creation of a 12 bed, 10 chair ambulatory assessment area, with a maximum length of stay of 48 hours, named the CAU.

Referrals for the CAU are taken direct from GPs, the UCC, Community Matrons and repatriated patients from our other Pennine Acute NHS Hospital sites. We operate a 24 hour/7day service which is medically led and commissioned by the local Primary Care Trust.

In setting up the CAU getting the right team was crucial. The selected staff have undergone a complete change in their ethos, perspective and roles in order to deliver the success of the CAU as a consequence they have evolved into a more efficient, understanding, empathetic and organised team who deliver an excellent service to the public.

This is the result of 'thinking outside the box' leadership. It is about having a co-operative approach to change. It is about embracing change from the bottom up and therefore taking ownership for change across all levels.

Our mantra is 'we never say no' we want the service to be used by as many service users as possible. The model we are developing embraces all possibilities; the philosophy of 'we can do' is paramount to our success. As a team we are constantly exploring new possibilities and ways of extending our service even further, putting our patients at the centre of everything we stand for.

My leadership and the leadership of my manager has enabled every member of this team to confidently develop their own important role by maximising their own potential, contributing to the cumulative success of the CAU. In addition to this, the leadership of my manager, her faith and trust in my capabilities and our joint vision for the future has allowed me the freedom to explore innovative care delivery and implement change almost on a daily basis. The ultimate beneficiary of this model is the patient.

CAU is a relatively young service, having only been in existence for 10 months at the time of writing. During this time we have received much positive feedback from patients and relatives regarding the excellent levels of care provided. Nevertheless we realise that we cannot simply rest on our laurels; we need to learn from mistakes made, eliminating the blame culture and using the lessons learned to improve our practice and do better next time. I feel that we have created an environment that is open and honest, where people can celebrate their success whilst also acknowledging that things sometimes can go wrong.

In addition to this it is important to realise that the NHS is not the creature it was, nor will it ever be again and we as leaders must evolve with the needs of the society that we serve. Keeping that in mind, my philosophy is to treat CAU as I would a successful competitive business, generating standards which include privacy and dignity, good manners, a smile, care and compassion, excellent communication and trust, knowledge and expediency. This approach must encompass the highest expectations of care delivery and all that this entails. Leadership is also about effective empowerment of staff to have belief in themselves and belief in what we, as a team, are trying to achieve.

In order to change the perceptions of nurses and motivate them you have to try to think how they think, acknowledge what is important to them and listen to what they have to say.

It has to be acknowledged that there are some 'bad apples' out there and that not all nurses deliver high standards of care but I don't think that this is generic. I feel that if nurses are encouraged to feel good about themselves, believe that their opinion matters and that it is their power that drives change forward, then the NHS would become fit to deliver healthcare for the 21st century.

Management is about control and power, leadership is about sharing that power, having the vision and innovation which enables the whole team to think outside the box and achieve their goals.

Involving patients – informing patients

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In 2010, in a radical shift in health strategy, the White Paper, 'Equity and excellence: Liberating the NHS' (Department of Health, 2010a) set out the Government's ambition to give people more control over their own care; to build health care around the needs of patients. At its launch, the Secretary of State for Health, Andrew Lansley said: "The first principle of the White Paper is that the NHS should ensure that for patients, 'no decision about me, without me' is the invariable practice.

It appeared that whilst clinical care might be very good, nurses sometimes treat patients as objects of nursing interventions, rather than people who need caring (Henderson, 2003), and often neglect to involve them in discussions and decisions about their care and treatment. But what is the evidence that involving patients in decisions about their care improves the outcome for the care delivered? Well, the short answer is that whatever nursing discipline you care to look at, there is evidence that doing this improves outcomes. Not only this, but listening to patients can also be cost and clinically effective. Generic improvements include (Coulter and Ellins, 2007):

• health literacy

• clinical decision making

• self-care

• patient safety.

We all have choices and decisions to make in our day to day lives, some will be complex such as buying or renting a flat, some are very simple, such as which brand of tea to buy. However, both these examples are very straightforward compared to some of the life changing decisions that patients have to make about their health. But they have one thing in common and that is information. Without information you cannot make a choice nor have any chance of making a wise one.

Historically, it was assumed that doctors would act in the best interests of the patient and prescribe care and make decisions about treatment on the patient's behalf (Deber,

1994). However, the NHS Constitution (Henderson, 2003) makes it clear that amongst other things, patients have a right to be given information. Patients may well have this right but it has been argued that healthcare professionals have substantial power over patients' decisions by controlling what information the patients receive (Department of Health, 2010b). It has also been suggested that nurses often believe that they know best, which prevents them asking patients to decide about their own care (Deber, 1994).

Perhaps the greatest change in the balance between the amount of information given by healthcare professionals and the amount of information that is available to patients is the internet; its growth triggering an 'information revolution of unprecedented magnitude' (Jadad and Gagliari, 1998). However, there is recognition that whilst there is some very good information on the internet, there is some that is not. Recognising that some form of quality mark was needed the Information Standard (The Information Standard, 2009) was introduced. Accredited information providers can display a logo; this gives patients (and indirectly health care workers) reassurance and peace of mind about the quality of the information. It should be remembered however, that information (such as leaflets or web pages) on their own have been shown to have little effect on patient outcomes, but the combination of oral and written information can improve patients' experience and, in some cases, reduce health service costs (Greenhalgh, 2009).

When it comes to health information and the patient there are three types: the expert patient, the patient seeking information and the patient who either does not want to know or doesn't know how to ask. An essential part of nursing practice is to assess patients for their individual, family (or carer) and support requirements. This assessment, amongst other things, helps nurses to identify the information needs so that personalised and appropriate information for the particular point in the patient's journey can be given. Nurses cannot expect to know the answer to all the patient's information needs but should know how to prescribe information and signpost patients to the local health information library or other sources of current, accessible and evidence-based information.

The concept of information prescriptions was set out in the White Paper 'Our health, our care our say; a new direction for community services' (Department of Health, 2006) where (by 2008), everyone who has a long-term need, and their carers, should be given an Information Prescription. An information prescription can be prescribed from the NHS Choices website (NHS Choices, 2012) and either printed out or emailed to the patient.

Being offered a choice is a good thing generally. When it comes to healthcare and the decisions that patients must make, nurses are in an ideal position to give information. As many have said, change is one of the few constants in the NHS. Nurses should accept the informed patient as a culture change and not see it as a threat. If their information is wrong nurses should correct it. If it is correct nurses should discuss it. Involving patients in their care is a team effort and the patient is part of the team.

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Is Nursing Working?

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Introduction

The Nursing and Midwifery Council Code of Conduct states; "Make the care of people your first concern, (by) treating them as individuals and respecting their dignity; respect people's confidentiality; collaborate with those in your care; provide a high standard of practice and care at all times; be open and honest, act with integrity and uphold the reputation of your profession".[1]

When considering good nursing care a 'vox pop' conducted in November 2011 identified that; "Nurses should treat all their patients with kindness, honesty, respect, dignity, an understanding of their vulnerability and quiet confidence" . When asked what was the singular most important feature of nursing care the overwhelming response was "the patient should be understood and treated as a person, not as a disease".[2]

There is a growing body of evidence that suggests that these aspirations are not being reached which raises the questions 'why' and 'could' and/or 'should' it be fixed. There has been no specific paradigm shift that has lead to this position but there has been creeping change over several years. The change of nurse education to a university knowledge-base system, the loss of direction over who is responsible for direct patient care and the lack of value placed in leadership over management.

Education

The move of nurse education from the hospital-based apprenticeship model to the university-based student model, and now from diploma to degree has caused much debate. Under the apprenticeship model the emphasis of nurse training was on gaining experience, learning the craft of nursing, under the guidance of a skilled supervisor. The gaining of knowledge was important but secondary.[3] The understanding of 'why' was not necessary for a nurse so long as she/he could 'do'.

The move to academic-based education shifted the emphasis from experience alone to a more informed knowledge-based approach. Some have argued that this was a period of the acquisition of knowledge for knowledge's sake and that there was insufficient integration of knowledge to fundamental nursing care creating the 'theory-practice gap'.

In gaining knowledge the nursing profession has lost focus on gaining the skill of caring.[4] They have underestimated the importance of this skill to the patient and its impact on the patient's quality of life. What used to be considered fundamental nursing care such as, getting to know the patient, working with them and their family to minimise the effect of illness, is no longer considered important in the rush for the acquisition of knowledge. If nursing is to be the autonomous profession described by the World Health Organisation[5] then improved patient care must first be achieved.

Following a degree level qualification it should be expected that the care of the patient is delivered as degree-level care. Commentators on degree-level programmes write of "the inclusion of aspects of cognitive learning which relate overall to the development of cognitive abilities' and 'the intended outcome is to produce a critical, autonomous professional, able to respond flexibly to different situations and capable of problem solving and addressing complex issues" (Miller et al, 1994). These are probably accurate aspirations but as a route to understanding, valuing and achieving excellence in the skill of caring they are falling considerably short.

Practical skills

Fears that nursing would be diminished as a therapeutic endeavour if the hands-on role were to be relinquished are often voiced. Such fears have been fuelled by the increasing role of the support worker taking on many of the tasks previously thought to be the domain of the qualified nurse; the qualified nurse having moved into taking over roles previously the domain of doctors. It is curious, perhaps, that the profession and others should believe that care has to be reclaimed by qualified nurses since there is little evidence that care was ever delivered exclusively by qualified nurses. There really never has been a 'golden era' of nursing care. Studies (Davies, 1992) of nursing activity in units providing care for elderly people persistently reveal that the majority of direct care

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1. An extract from NMC Code of Professional Conduct
2. These views have been collected by a simple 'vox pop' conducted by the author, of 27 people in Oxfordshire and Warwickshire. They represent a range of ages but mostly adult, the sexes reasonably balanced and some ethnic diversity but largely white middle class.
3. 'The element of apprenticeship is regarded by most of the leaders of the nursing profession, at least in this country, as a far more important part of a nurse's training than her theoretical studies'. (The Lancet Commission, 1932)
4. This paper makes a distinction between the intuitive characteristic 'to care', and the skilled technique of giving care.
5. The World Health Organisation states 'nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people'

has been provided by 'nursing auxiliaries'.

However, this misses the point. Patients suffering physical or mental illness are saying that they want to be cared for in such a way as preserves their dignity, respects them as human beings, not simply a disease, and keeps their basic human needs provided for, such as adequate diet, adequate fluid balance, warmth and comfort. If this is the perspective of the patient then, clearly, this is not being achieved, whatever the profession may argue. The time has come for all those involved in healthcare to understand that patient care is not good enough and that devolving the skill of care giving to an unqualified and insufficiently supervised workforce is not working. All patients are given a medical diagnosis but a nursing diagnosis which identifies the way that the illness affects the person and their lifestyle and goes on to prescribe ways to minimise the effects of the disease or ameliorate them and who should provide this care may help. However, it must be recognised that this is not simply a nursing problem but that the answer lies within the whole system.

Leadership

Over the past 50 years the leadership in nursing has been undermined and diminished. This may or may not have had an impact on the standard of care giving. In 1998 Alan Milburn (Secretary of State for Health) announced he was reintroducing the matron to ensure that the patients received the care they needed. His plan, of a senior level nurse free to visit clinical areas to provide support and to address local shortcomings, has not been a resounding success. The ward manager /sister should have detailed knowledge of every patient at their finger tips, she/he should know the nursing staff and medical staff sufficiently well that those who need more support are not left exposed and the patient care is constantly at the heart of ward activity.

Trust Boards have a substantial role to play in ensuring good care giving. The leadership provided by the Board should engender a total commitment to the primacy of good care. Although there are Nurse Directors on all Trust Boards few lead detailed discussions about patient care and a real understanding by boards of the impact of budget management and achievement of targets to improving the patient condition? Nurse Directors are in a position to visit clinical areas every day and to keep their directors colleagues fully informed of the quality of the activity. It should be a matter of good corporate governance for boards to understand the experience of the patients in their care. Evidence from Mid Staffs, Maidstone and Tunbridge Wells, and High Wycombe and Stoke Mandeville and others; demonstrate the failure of Trust Boards to be informed of, and to take appropriate action on, good patient care. In saying that 'The fish rots from the head' Bob Garrett (1996) explained that when an organisation fails it is the leadership that is the root cause.

Conclusion

Nursing is one of those occupations that seldom call for clarification. From little girls with career aspirations to politicians legislating for healthcare they all intuitively 'know' what nursing is. Sadly such intuitive 'knowledge' is found wanting. 'Is nursing working' is a good question if one is sure what nursing is. In order to value and provide skilled care nurse education needs to understand and be committed to preparing nurses to provide skilled care; the performance of the skill of caring should be in the hands of those appropriately educated to provide it; and the organisational, professional and national leadership must have at its heart a total commitment to skilled patient care.

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Adapting to new technologies; making the big changes to delivery of care

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Adapting to uncertainty

Now that the Health Bill has passed into the statute books (Department of Health, 2012), it is perhaps opportune to consider the role of the nurse in the new landscape it represents. Clinicians have been tasked with commissioning or delivering top quality health services for their local communities, on the assumption that they a) know what their local communities need and b) that there is a 'best' way of providing it. Terms like 'clinical leadership and responsibility' and 'evidence-based, cost-effective care' are used to describe the skills, drive and confidence needed to implement change, and the knowledge to differentiate between those interventions that work and those that do not. The sheer pace of change within the NHS and the current pressure to deliver better service and improved patient outcomes at reduced cost are constant and compelling drivers.

Historically, leadership and the ability and confidence to appraise, judge and implement research findings in practice are not skills that nurses have necessarily been able to prioritise in day-to-day clinical practice. However, the explosion in online health information and the rising public expectations of 21st century healthcare mean that nurses' opinions, recommendations and advice are being sought and challenged at a previously unprecedented scale.

Addressing uncertainty; critical appraisal and understanding of evidence-based healthcare

The last twenty years has seen a step change in the way that researchers evaluate the impact of nursing interventions. In many areas, there are now significantly extensive bodies of research evidence available to enable systematic reviews and meta-analysis of nursing interventions to take place (The Cochrane Library, 2012) and to allow practice to be improved as a result. However, the lack of literacy, numeracy, and critical appraisal skills among many nurses remain significant barriers to widespread implementation of research findings and therefore to improvements in delivery of care. On an individual clinical basis this is arguably less important, but if nurses are to work effectively and equally within the multi-disciplinary team environment, then nurses must be able to base their recommendations on sound evidence that stands up to scientific scrutiny. Differences of opinion between professions about what the 'right' care is for a specific patient will always exist, but nurses need to develop the skills to articulate an evidence-based case for a specific course of action that they can use to challenge their professional colleagues when necessary. As an eminent nurse researcher has said, "Opinion is the child of subjectivity and subjectivity is the child of sloppy methods. Therefore, opinion is the grandchild of sloppy methods" (Watson, 2003).

Similarly, healthcare service re-design should be based on best evidence where appropriate. It is well recognised that research can take decades to translate into changes in clinical practice, but the same can be said of the National Health Service's inability to take successful pilot studies and translate them into widespread clinical practice. There may be many reasons for this, but an important factor may be front-line clinicians' inability (or unwillingness) to search out, critically appraise, consider and develop potential local applications of cost-effective service interventions. If nurses are to develop their roles as commissioners or providers of cost-effective health services, then they need to develop skills in service redesign and healthcare improvement that have been developed and applied in clinical settings. As money gets tighter and health and social care services are scrutinised, nurses must collectively become effective advocates for high quality healthcare, wherever it is delivered, based on the needs of their patients and not by the political landscape of their local community (Walker, 2011).

Leadership based on knowledge and evidence of what's right rather than opinion

Whilst there is more to clinical leadership than the implementation of evidence-based practice, this remains an important factor. Despite managerial re-organisations nurses have a greater degree of control over their actions and behaviour on a daily basis than those who seek to influence and control their behaviour from the top. Given that nurses represent one of the largest groups of healthcare professionals with day-to-day contact with patients, then learning to make individual evidence-based improvements to daily practice could raise standards of services significantly. It is worth noting that 'leadership' does not always have to be defined by highly skilled, high profile management roles (although there are now fantastic opportunities to develop such skills (National Institute for Health research, 2012) but can also be achieved through the sharing of individual self-reflection, acquiring basic skills in accessing and appraising summaries of research evidence (e.g. https://www.evidence.nhs.uk/) and making changes to every day clinical practice.

However, there is a significant role for nurses to develop roles in educating, influencing and leading others although again, these are skills that may not always sit comfortably with the traditional nursing model of care. This type of leadership requires confidence, knowledge of best practice in relation to the local community and the effective engagement of nurse teams. These nurse leaders also need the time and space to question their own practice and to consider the introduction of new and more effective way of delivering services. All this needs supporting by access to information about clinical practice and the development of organisational cultures that value such information and encourage it use as a vehicle for improvement of performance.

All of this may sound complex and challenging to deliver, but the sheer size and diversity of the nursing workforce should mean that there are a sufficient number who have or could develop the skills to take on these roles. This is the challenge for our community….

Summary and recommendations

Nurses have a powerful voice in the NHS which is often under-used and underrepresented. Collectively, we have the power and the potential to deliver great improvements to the care of the patients we seek to represent. The ability (and willingness) of nurses to differentiate between (cost-) effective and (cost-) ineffective healthcare, to develop the skills and knowledge to change and improve their practice as a result and to use that knowledge to influence others are vital factors in the delivery of high quality patient care in the future.

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Technology: Changing the role of the nurse

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Advances in technology have changed the face of nursing. Technology to help with patient care – in the form of pumps, monitors and infusion devices have all grown exponentially over the years. Next, we had technology to help with communication and record keeping. There to help with 'streamlining' recordkeeping, ease the burden of bed management and patient flow through the hospital. There to help us finally decipher a junior doctor's handwriting, and in turn reducing the risk of misinterpretation and therefore providing a safer environment for the patient. However, in the 90s the new ward computer sat on the desk, gathering dust as we occasionally turned it on to see what it could do for us. How much things have changed since then, how far we have come. Or have we?

There is a difficult juxtaposition between nursing and technology. Nurses are the patients' advocates, first and foremost. As we progress through our careers, we progress from managing a handful of patients on a ward or clinical environment, to managing all the patients and staff in that area. We become managers, executives, conductors, statisticians, chief cook and bottle washers; at the very heart of the successful running of the hospital, clinic or theatre in any healthcare organisation. We have done it all by holding a wealth of information in our heads, flexing and juggling on a minute-by-minute basis. Success depended on the individual skills and ability to adapt to this tall order.

Our training and experience as nurses ensured we developed these competencies. To manage an individual patients' care, we also had to conduct, manage, flex, juggle and above all maintain all the relevant information in our minds to ensure we did not forget any aspect of the patients care, but also anticipate what may happen and adversely impact their recovery.

The question is, what has all this got to do with technology and nursing care? I believe the two are intrinsically linked. We now have help to ensure nothing is forgotten – electronic reminders, flags, calendars, and appointments. We have help to anticipate any future issues for our patients – monitoring and trending, for example. There

is a wealth of knowledge at our fingertips – no longer trekking to a library to photocopy a tome of articles – type your query into a search engine and answers appear. Prescriptions are filled using barcode technology. References can help ensure the right dose is delivered to the right patient at the right time.

None of this will ever remove the need for good clinical judgement, but it can and will assist and help with the sifting and organising of all the relevant information we gather about our patients. It will change the way we manage the patient environment.

The power of the possible was revealed to me when working as a nurse advisor on the NPfIT programme. The main objective was to have one centralised patient record, accessible from wherever the patient was located in England. So if Mrs Jones was registered with a GP in London and became ill and admitted to hospital in Carlisle, the hospital could easily access all her patient records and so treat her safely and effectively. That was the theory.

The practical aspects were more opaque. Records were traditionally maintained in many and varied ways – most were developed from templates with local adaptations, useful to the local clinicians, but sometimes a mystery to those outside the locality. Agreement on the shape and form of even the front page of the electronic record caused endless debate – one voice of dissent could put the brakes on a potential breakthrough. Success was achieved in some areas – booking systems, PACS - radiology; the advent of the mobile reading device for x rays was revolutionary – truly. It demonstrated the potential.

Maybe the project was too far, too fast. The vast majority of senior clinical staff in 2012 did not start their careers using technology. In that environment, it is easy to see why clinicians might view advances in this kind of technology with suspicion and trepidation. We must ensure information technology is an integral part of the nurse education programme.

Nurses have always been (and have wanted to be) at the patient's bedside. Anything that comes between the nurse spending time with the patient is traditionally viewed with suspicion. Even in the days before computer meetings, writing up reports, care plans and handovers, being held away from the bedside or out of sight of patients, caused anxiety in the patient and suspicion in other staff.

Yet using mobile devices would help with keeping the nurse by the patient's side. Most people can use a smartphone, as they are intuitive, so it's a small step to imagine a nurse

carry a mobile device that enables him/her to remain close to patients, and contains all the information they could possibly need. Light, portable devices are in some cases small enough to fit in a pocket. In conjunction with an array of advances already in place (wireless communications, workflow management systems, wireless patient monitoring, electronic prescribing & administration with bar coding and electronic clinical documentation (California Healthcare Foundation, 2008)) handover, accurate and safe care planning, prescribing and monitoring can all potentially be done in one place. With the ability to cross-reference and manage all the information sifting sorting and organising, "integration can add significant value to the way nurses co ordinate and provide care" (California Healthcare Foundation, 2008).

And therein lies the paradox. Technological advances that can assist, organise and provide more safety in delivering care are often rejected on the basis that they are unreliable or can give cause for misunderstanding when in reality they are poorly understood. Indeed, questions are asked about why staff are logging onto devices instead of spending time with patients. The perception is that this is not care. What's to be done?

We can employ 'champions' as role models; those clinicians who can not only see the bigger picture and the potential, but who can also motivate and influence staff to feel more positive and confident in utilising all the technological advances available to them. We must take time to make it work. Above all, explain to patients and nurses how they can benefit. Encourage a multi-disciplinary approach to the use of electronic devices and persuade professionals that this is the future – for it surely is - and then take it to the patient's bedside.

Technology is not going away, and, as a profession, we must embrace it. There is no alternative.

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Delivering good care without increasing the cost; why quality matters

June Andrews,
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Introduction

The greatest tragedy about the delivery of care by nurses is that so much of what they do is often futile. Nurses spend an awful lot of time doing things that don't make any difference, and in some cases, they spend time doing things that are known to make things worse. In addition, when they are doing things that really can make a difference, they find themselves running out of time, usually because they are badly organised.

In a nursing team, or for an individual nurse, the only thing that is rationed is time. There is only so much that can be done in the time allocated for any one patient encounter, and there is a limit to the number of patient encounters in any one span of duty, or one clinic.

The problem arises when the individual nurse cannot distinguish between unnecessary and pointless interventions and those that make a difference, or when the system makes it easier for the nurse to fill their allotted working hours with trivia.

In discussion with nurses they will often claim that they are held back in doing what ought to be done by paperwork, or routines that are demanded by employers and inspectors. They are harassed by phone calls and emails, meetings and unplanned interruptions into what they are trying to do. Of course there is a case for this. But when you look at the quality of the paperwork, and the effectiveness of the phone calls and emails, and the badly organised meetings, it is clear that they are not excelling at those tasks either. When challenged they will claim that these overwhelming jobs take a priority over other things that might demand their time and attention. In an apparently overwhelming tidal wave of demands on the nurse during any span of duty, it is as if the tasks choose their own priority. The nurses behave as if they have no discretion.

In reality the problem is sometimes that the nurse lacks sufficient authority and personal effectiveness to challenge the pointless activities that the system asks of them. At times this personal ineffectiveness could be mistaken for a kind of passive aggression. "I know that doing this stuff won't help my patients, but the one in charge says I must do it, and so I will. It's more than I can be bothered to do, to tell them how their routines and requirements are increasing length of stay, or patient cost, or adverse incidents or complaints. And if the relatives notice it and point it out, I'll wash my hands of the problem and tell them I am too tired/busy/overworked to deal with their issue." The damage is done and the nurse takes flight into being a victim.

A lot could be done to improve what is effectively a quality issue, by getting nursing staff to be more focussed.

"Recently my dad was catheterised at home by the district nurse. She was in the house for ten minutes and never washed her hands in that time. When I got to his house he knew that she was tired, her car was playing up, there were only three nurses on for the county, and that she thought errors might occur because they were so busy. He did not know that he could (in fact really must) take more frequent showers to keep himself clean and that the bag should always be lower than his bottom to keep the urine running out, or that he should drink a lot of water and aim to make the urine paler. She was busy and harassed, but she completely missed the chance to help him other than introducing the tube. But she was not too busy to share all her problems with him. He won't complain in case he needs her again."

The nurse needs some simple rules. Don't talk about anything other than what is related to the patient's care. Ask lots of questions about how they are and listen to the answer. Conceal from the patient as much as you can if the work is giving you stress. You need to tell someone, but don't wreck the possibilities in the patient encounter by getting your own problems to take priority over that of the patient.

The best example of this no cost, high impact, quality improvement in a hospital setting is intentional rounding. If the nurses regularly go and ask how patients are doing, and listen to the answer every hour of every day, the unexpected and adverse incidents drop away, along with call buzzers and other disturbances. It is not rocket science.

The evidence is there. It is time for nurses to just do it.

Making Humanity Matter

Julia Manning
Chief Executive, 2020health

It has been concluded by some anthropologists that evidence of civilisation is not when man-made tools are first found, but when healed bone fractures are discovered. For a facture to have healed indicates that this human being was fed and cared for until they had recovered.

Life is about caring relationships. We are defined by them – mother, son, aunt, grandfather, partner, boss, carer etc. It is in our relationships that we are first cared for and in which we first have the chance to learn and value what caring for others means too: compassion, comfort, sympathy, kindness, listening etc. Relationships are our greatest test and can be the greatest source of happiness. Developing the emotional intelligence to handle, extend and appreciate our relationships with family, friends, and work colleagues is vital to our wellbeing. How much we value each other and what that means in practice in terms of time, gifts, affirmation, touch and kindness is a bell-weather of a healthy society. So it would be remiss to simply look at one sector, be it nursing, management or any other, and critique it without reflecting on what is happening more widely in society.

We live in a world where technology means we don't have to be out of contact, ever, yet there are (at least) two major societal trends which are undermining the value of caring relationships. Without thinking these through we will only ever be sticking plasters of platitudes on the recurring wounds of those who have not been cared for, or left to console on another occasion in the future the families have been scarred by the lack of care.

The first trend that undermines caring is materialism. We have become a society that gives priority to things over persons. We know the price of everything and the value of nothing, and people who are frail and elderly are seen as a biological losers, not producers or net contributors to society. Whilst caring for someone who will get better and be able to contribute is seen as valuable, caring for someone who is confused or dying is regarded as pointless. There is no material gain.

We have heard a huge amount about dignity in the press, but all too often it is being related to independence. It seems to me that dignity is being confused with autonomy. True dignity is intrinsic, it is bestowed – how we are treated, loved and nourished as human beings - not dictated by how we look, what we own, what we can do or say or feel. This kicks against the zeitgeist: that we are supposed to be in control, able to choose our destiny, acquiring and consuming the indicators of our worth. Whilst young people grow up thinking that designer trainers are more important than eating, we can't expect them to value very highly caring for others. 2020health recently supported a cross-party inquiry into unplanned pregnancy. Part of our research revealed the longing amongst young people to have the chance to talk about relationships. They were not wanting to talk about the biology, but about emotional resilience, confidence, self-worth and negotiating skills they realised that they lacked. Life skills that were once acquired in the home are being neglected. And the second trend is one of the key reasons why.

Technology is a tool, not a panacea, it doesn't transcend the need for caring. Whilst technology has given us amazing opportunities to remain in contact 24/7, simultaneously with this opportunity for connectedness has come a parallel escalation of isolation, loneliness and loss of social skills. If society means a unified group of people who are like-minded, collaborate and share real experiences, with our ever increasing modes of 'socialising' we have become less and less an actual society. Several older people have said to me recently that 'the phone doesn't ring anymore'. The first transformational technology that allowed people to communicate immediately across far distances has gone out of fashion. In our busy lives, a quick text or tweet is supposed to suffice, but for those whose lives are more restful, neither the doorbell or the phone now ring.

As young people grow up they normally learn social skills through observing social exchanges , interacting with their environment and from moral guidance. Often without thinking, technology (in the form of TV, computer games, mobiles) has been allowed to reduce human contact to a level such that children are arriving at school without the necessary social skills or vocabulary for communication, interaction with other children or understanding of covert messages in speech and behaviour. Over time use of text messaging increases, with the concurrent loss of non-verbal communication cues such as tone of voice and body language. Ask any secondary school teacher and they will roll their eyes at the amount of grief caused by miscommunication on social media (let alone the deliberate cyber bullying) outside of school that then spills into the classroom.

A young adult with under-developed social skills is not going to have a learned or intuitive appreciation of how someone else might be feeling, either emotionally or physically. They will have poor relational skills and if combined with the first trait of being materialistic, will not have the emotional intelligence that we expect of an adult.

Someone who doesn't value people, or even looking after themselves, over things, and who hasn't learned the importance of good communication is not going to make a good carer, no matter how smart they are. If we are caring less in our personal lives, that will transfer into our public and working lives. We take our values to work – beliefs and worldviews may be personal but never private – they shape our thinking, attitudes and actions.

It is also important to acknowledge that there are health professionals who have in abundance the 'softer' skills of listening, sympathising, holding someone's hand, considering someone's comfort or anxieties, and have been frustrated by a rigid emphasis on efficiency and cost-effectiveness. It is difficult for the latter to contain measures of the consequences of good holistic care which could mean quicker recovery, less anxiety and fewer readmissions.

So in thinking about the nursing profession in this book with the many commendable recommendations and advice, we will only be partially, and maybe temporarily successful in bringing about any improvement in nursing care and reputation if we don't at the same time take a hard look at the society we have become. Simply to tackle the culture at work is not enough; if we don't raise the status of caring across society then nothing lasting will be achieved. And that includes caring for children, caring in care homes as well as for the sick in the community.

There is an opportunity here for the government, society and the NHS. The financial reality is that we simply can't afford to employ ever more NHS staff to meet the needs of older people in hospital, who make up two thirds of inpatients with 30% of them having dementia.[i] The NHS of today has completely different demands upon it compared to sixty years ago, and we have to adapt to this. The cultural reality is that we need to encourage caring – as a common good and as a responsibility.

Many of the distressing stories we hear of inadequate care stem from patients not having help with basic needs such as assisting to the toilet, feeding and drinking. If you have 20 patients all being served lunch at the same time and 15 of them need help with eating, it's an impossible task. The time has therefore come for relatives and friends to be expected to assist with in-patients, just as they would if that person was still at home. Hospitals should both welcome and require help from the patient's family, and this should be stipulated in the NHS Constitution which is due to be redrafted. It won't always be possible, just as jury service isn't always possible, but those who can would add to the existing volunteer hospital 'friends' who already see it as a good thing to support their local NHS.

The Francis Report should be an opportunity for us all to reflect on how much we value caring. This is no bad thing, as Socrates said, 'the unexamined life is not worth living'. It's a chance we must not miss, and we mustn't think simply applies to the nursing profession. It applies to us all. The founder of the Ritz Carlton hotel chain was once asked what was the secret of his success? He said that to everyone in the company, whether a receptionist, manager or cleaner, the maxim was "Ladies and gentlemen serving ladies and gentleman". If we, or even the NHS as a whole, can regain this as our attitude towards each other, serving, caring and respecting each other no matter our role or age, then there is hope for nursing, and Francis could initiate a lasting legacy.

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Too Posh to Wash?
Reflections on the Future of Nursing

2020health's mission
Creating a healthy society

2020health is an independent, grass roots think tank whose purpose is to both improve individual health and create the conditions for a healthy society, through research, evaluation, campaigning and relationships.

2020health research and activity includes the following workstreams

Fit-for-school:
To create a holistic picture of wellbeing and what children need in order to thrive at school, and identify ways of enabling more children to flourish and break the cycle of failure.

Fit-for-work:
To continue looking at the importance of work for health and health for work, and ensure that those who experience illness receive timely and appropriate support, understanding that worklessness impacts on economies and society as a whole.

Fit-for-later life:
To look from active retirement, to increasing dependency and end-of-life care and consider new models of provision, raise the status of caring, embed respect for ageing and ensure inclusion.

Forgotten conditions:
To ensure that people with rare or unusual health conditions have their needs met by the NHS.

Integration:
To promote integrated care that uses technology to empower people and enable management of their healthcare and wellbeing.

International:
To ensure that we continue to share our knowledge of healthcare and learn from those countries that care for people better than we do.

Innovation:
To ensure that people have access to innovation in all its forms and keep the UK at the forefront of R&D.

Social Care:
To find sustainable solutions to ensure people's vulnerable or final years are the best they can be.

"2020health provides an invaluable forum for those who are interested in development and reform of the health service. Its meetings are always stimulating and thought provoking."

Rt. Hon. Stephen Dorrell MP,
Chair of the Health Select Committee

"2020health are unique in understanding the potential of technological innovation and marrying it to the real world challenge of NHS adoption. They truly understand the importance of patient advocacy."

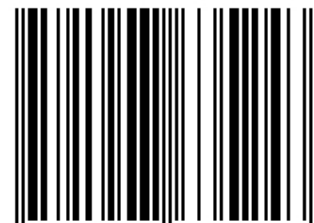**Steve Bates, CEO of BioIndustry Association**

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