Royal College of Nursing response to Health Education England’s and the Nursing & Midwifery Council’s call for evidence on the *Shape of Caring* review

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Report prepared by:

Chris Watts,
Research and Innovation Manager

Dr Stephanie Aiken,
Assistant Head of Nursing: Education, Learning & Development

[chris.watts@rcn.org.uk](mailto:chris.watts@rcn.org.uk)
[stephanie.aiken@rcn.org.uk](mailto:stephanie.aiken@rcn.org.uk)
Summary of key points

This report is the response of the Royal College of Nursing (RCN) to the call for evidence on the Shape of Caring review. The Shape of Caring review, which is being led by The Lord Willis of Knaresborough as an independent chair, aims to ensure that throughout their careers nurses and care assistants receive consistent high quality education and training which supports patient care.

The RCN response is structured according to the themes that the call for evidence stipulates, and for brevity these are presented in this summary under the headings of: understanding best practice for public and patient involvement; education, training and career progression for a regulated health care assistant workforce; flexible, high quality and sustainable professional development for all nurses within a national nursing career framework; and investment in research and innovation (skills and practice).

Our full response includes under each theme a discussion of what we consider to be the issues as we understand them, and where there is work being undertaken to address these, including work being undertaken by the RCN, our members and partners. We have included both national and international perspectives in these discussions. Finally, within each theme we also make recommendations or observations about solutions going forward.

Understanding best practice for patient and public involvement (PPI)

- Understanding best practice in approaches to PPI is key to ensuring patient and carer voice and service user involvement across education and training
- The RCN is proactive in researching PPI and its application through our research programmes at the RCN Research Institute, University of Warwick
- The RCN is working in a range of additional ways to support and showcase the importance and value of PPI within its portfolio
- Of key importance is understanding the nature of the contribution from patients and the public and ensuring they themselves fully understand the current and future nursing roles and the education required for those roles

Education, training and career progression for a regulated HCA workforce

- Valuing the Health Care Assistant (HCA) workforce is routed in identifying and developing potential in all workers, including involving them in decision making on the future direction of the workforce
- There is a need to widen opportunities for career progression within a national nursing career framework
- Regulation of the HCA workforce can help reduce unnecessary variation in training and development, but requires consensus on the knowledge, skills and competencies HCAs require to provide effective care and add value to the healthcare system
- While examples of widening opportunities for HCA career progression do exist, these tend to have been developed at local levels in response to operational need
- The HCA workforce needs robustly evaluated programmes of education and further training (such as the RCN’s First Steps resource) within a national framework of HCA career progression, linked to regulation and accompanied by appropriate support from all senior staff, particularly line managers. This is key in enabling more seamless progression routes for the healthcare workforce
• Investment in training and education needs to be accompanied by policies and initiatives that widen access to those opportunities
• Research indicates there is potential for considerable benefits in developing and evaluating HCA training programmes, including: improved confidence and cross-team working, a freeing up of nursing time together with confident and appropriate delegation of activities, reduced staff turnover, improved clinical outcomes and more effective patient communication skills.

**Flexible, high quality and sustainable professional development for all nurses within a national nursing career framework**

• To ensure flexibility, future models or frameworks for CPD need to be responsive to different needs of the nursing workforce, particularly variations in access to support and development across different staffing groups
• There is a need for collective understanding and consistency in the terms used to describe provision of education and training (such as competencies and capabilities)
• A consistent approach is also needed for accreditation of prior learning (APL) for pre and post registration programmes, and future work carried out to understand and promote innovations and best practice in this area
• More and more robust research is needed to understand how models of clinical placement provision impact students’ knowledge and skills development, confidence to practice in a range of settings, as well as influencing their future career choices
• This should be achieved through a well developed, implemented and evaluated / researched induction and preceptorship programme supporting newly registered nurses’ transition into their role, together with an outcomes-based career framework that enables staff to map learning opportunities against competencies and capabilities.
• There should also be investment in understanding the internationally educated nurse’s experience from recruitment to transition into the UK healthcare context and how their CPD needs can best be met
• The RCN is commissioning a project to enable us to develop an informed, evidence-based contribution to current debates around mentorship and practice based learning for nurses. This will include an understanding of the evidence base for how the mentorship role might be differentiated in the future. We will use this information, together with outcomes from the *Shape of Caring* commission, to review and refresh our current provision of resources supporting students and their mentors
• Specialist nurses and nurses working at advanced practice level have a key role in the formal and informal education and development of others, particularly other nurses and HCAs. A programme of work at the RCN will investigate and describe the importance and application of such roles in formal and informal contexts
• Nurses acting in leadership roles and acting as role models play an important part in ensuring a flexible and high quality learning environment for future education and training needs, although leadership in nursing requires investment in what is currently an under-researched area
• The RCN has authored, together with our stakeholders, a large variety of frameworks describing and mapping professional competences. Much of this work is conducted through RCN member forums, and thus tends to focus on areas of nursing specialism.
• While valuable, in the absence of integrated career frameworks, the impact of this work will always be limited and correlate to the good will, or buy in, of regional and local educators and providers
• A national nursing career framework will ensure that there can be a shared expectation by all that a specific nurse, in a specific role needs a specific set of CPD activities
Investment in research and innovation - skills and practice

- It is essential to create a culture of research, innovation and knowledge translation in order to future-proof the nursing workforce. Real evidence-based practice must be the modus operandi of future nursing care.
- This ambition is central to the RCN’s Knowledge and Innovation Action Plan 2014 - 2018, which underpins our work in supporting nurses to use knowledge in policy and practice, and to feel confident in using research and innovation to enhance care.
- The RCN Research Institute has a programme of research looking at implementation of evidence into practice.
- Clinical-academic nurses and advanced practice nurses play key roles in promoting uptake of evidence through role modelling, teaching, clinical problem solving and facilitating change. In acting as experts, champions and boundary spanners, these roles are important in the diffusion of innovation and transfer of knowledge.
- With promising examples of sound return on investment emerging, more work should take place to ensure that clinical academic careers are developed, expanded and implemented. This will require national coordinated investment as well as local organisational investment.
- Investment is needed to incentivise organisations to encourage their staff to participate in and lead research projects, including funding back-fill for staff to accommodate commitments to research activities. Funding and commissioning should be linked to scholarships to encourage nurses to undertake further learning and development.
Introduction

With a membership of around 415,000 registered nurses, midwives, health visitors, nursing students and health care assistants, the Royal College of Nursing (RCN) is the voice of nursing across the UK with a dual operational role as both a professional organisation and a trade union. Our Royal Charter explicitly states one of our keys aims is “to promote the science and art of nursing and education and training in the profession of nursing.” Our professional activities extend to all aspects of the nursing training and education landscape across all nursing contexts and specialties for the wider nursing family. Partnerships with key organisations inform all aspects of our professional offer in this area, including with NMC, HEE, Council of Deans, Skills for Health, Skills for Care and through our RCN Research Institute based at the University of Warwick.

The RCN is in a unique position to influence health education policy and practice both across the four countries of the UK and at a European level. We work with a large number of European organisations in the development of best practice on a range of professional and regulatory issues at a political and legislative level. Included in our key partners are: the European Federation of Nurses’ Associations (EFN), the European Federation of Public Sector Unions (EFPSU), the European Public Health Alliance (EPHA), the Commonwealth Nurses and Midwives Federation (CNMF), the International Confederation of Midwives (ICM), and the European Forum of Nursing and Midwifery Association and WHO Europe (EFNMA).

Through these and other partnerships, the RCN is strategically placed to influence key international developments in nursing education, all of which have significant bearing on the UK. The RCN also provides advice and support both formally and informally to various EU projects impacting on nursing. For example, the RCN played a key advisory role in a project initiated by the European Commission to exchange knowledge about educational standards and legal regulations of employment for health care assistant staff within the healthcare sector.

We are well placed to support the interprofessional leaning agenda which is of increasing importance in educating the healthcare workforce of the future. We have forged strong relationships with other Royal Colleges to address shared agendas, including exploring how to develop the future workforce to meet changing patient needs. We believe that this joint working affords opportunities to engage in debate and forge agreement about development of curricula to support a future flexible workforce and the emergence of common standards and language to promote interprofessional synergy.

Through our work to address the needs of our health care assistant members, the RCN is recognised as an importance contributor to a range of different bodies to share expertise in the development of this workforce.

Background

Structure of this report

This report is the RCN’s response to the call for evidence on the Shape of Caring review. We have structured this response according to the themes that the call for evidence stipulates. We have included under each theme a discussion of what we consider to be the issues as we understand them, and where there is work being undertaken to address these, including work being undertaken by the RCN, our members and partners. We have included
both national and international perspectives in these discussions. Finally, within each theme
we also make recommendations or observations about solutions going forward.

The call for evidence requests that we indicate where evidence submissions describing good
practice have been evaluated. In general, our observation is that there is little formal
evaluation of these programmes of work. This probably reflects where nursing education is in
its evidence journey, but we would support the observation made by Nutley et al (2013) that
there is a need for debate around what is ‘good enough’ evidence and the development of a
range of funded schemes addressing standards of evidence. The RCN is pro-actively
addressing this, through the evaluation of our First Steps resource for Health Care
Assistants (HCAs) described in the report below, which pilots an impact evaluation model.

A note on terminology. Care assistants have numerous descriptors, including Health Care
Assistants and Health Care Support Workers. For consistency, we use the abbreviation
HCA (Health Care Assistant) throughout. It should be noted that, in submitting evidence for
each of the eight themes, the RCN has drawn on both UK and international evidence. For
the latter, the use of the term, ‘Healthcare Assistant’ is not universally defined or recognised.
Consequently, there are significant disparities in the nature and duties of the HCA role, with
Australia and the United States (US) providing just two examples of multiple HCA career
paths under various professional titles, some of which are regulated and others which are
not. It is important then that the reader understands that international comparisons will not
immediately cross-over to the UK context and that in this paper the use of the term ‘HCA’
invariably refers to a diverse set of roles.

A selection of some of the comparative terms used in other countries and the extent to which
HCAs are regulated within these jurisdictions is provided in appendix 1.

Overall context

Nursing is both an academic and a practice discipline, which is reflected in the current pre-
registration curriculum framework. However, whilst much has been written around the theory
practice gap in nursing, many challenges around how to support the transition of knowledge
into practice remain. Whereas traditional curricula models in healthcare tend to address
learning about practice, there is a need to explore more innovative ways to support learning
in practice to increase opportunities for engagement in development activities which can be
seen to have a more immediate impact on care. This includes ways of supporting those
undertaking learning activities to achieve requirements to enable safe and effective practice
(the students) and those who supervise them (mentors and preceptors).

The integrated care agenda requires an understanding of how the healthcare workforce
needs to be developed to deliver this. Current healthcare education programmes are
predominately acute and hospital focused and centred within the NHS context. The evidence
base around integrated care needs investment if we are to understand and meet the needs
of an integrated workforce and open up new practice learning opportunities for students. The
RCN is undertaking a range of work to understand the full implications of integrated care.

Access to training and education that has been robustly evaluated for efficacy continues to
be problematic for nursing staff. We address the need for more comprehensive and
meaningful evaluation of initiatives under theme 7 of this report on research and innovation.
On access, we has seen challenges in staff having limited access to training and CPD (RCN
2013f) with our 2013 membership survey indicating an increase in over a third (38 per cent)
of respondents who received no CPD provided or paid for by their employer, compared to 28
per cent in 2011. Older nurses (aged 55 and over) are less likely to receive CPD than
younger colleagues, while only six in ten respondents have a personal training and
development plan. In Northern Ireland, the most recent staff survey conducted by the Department of Health Social Services and Public Safety NI (DHSSPSNI) in 2012 and published in 2013, highlighted the fact that only 43% of HSC nursing staff in Northern Ireland have an annual appraisal or development review. Almost half (49%) do not have a personal development plan and, of those that do, less than half (48%) receive the training, learning or development identified in the plan. Only just over half (53%) of all HSC nursing staff believe that there is strong support for training from their employer.

The RCN report *Beyond Breaking Point* (RCN, 2013g) highlights issues associated with the experiences of BME nursing staff, who appear to have restricted access to career development and are shown to be underrepresented in more senior positions of the workforce and report experiences of marginalisation. This survey suggests that some BME nurses feel that they are not given support in career progression and in some cases feel marginalised among their own teams. *Beyond Breaking Point* also points to considerable levels of stress in the workplace, with nursing staff reporting heavy workloads, staff shortages and feeling pressured to work beyond their scope. All of these issues impact on nursing staff ability and capacity to undertake development and training.

**Theme 1: Increasing the patient / carer voice and service user involvement across education and training**

**Summary**

Understanding best practice in approaches to patient and public involvement (PPI) is key to ensuring patient and carer voice and service user involvement across education and training. The RCN is proactive in researching PPI and its application through our research programmes at the RCN Research Institute, University of Warwick, which is a centre of international reputation in this area.

We also have numerous examples of the learning from this research being put into practice nationally, with RCN Nursing Team specialist advisers integrating service user involvement into activities to support nurse education and training. This work illustrates the diverse considerations required in achieving successful PPI across different patient and service user groups.

The RCN is working in a range of ways to support and showcase the importance and value of PPI within its portfolio. What emerges is the importance of understanding the nature of the contribution from patients and the public and ensuring they themselves fully understand current and future nursing roles and the education required for those roles.

Supporting PPI in education and training programmes requires recognition that, whilst individuals hold expertise in their experiences of disease and health behaviours, the wider public often hold stereotypical beliefs, perpetuated through the media, about the level of education nurses require. This could hamper meaningful contributions and therefore there is a need for programmes of work to include opportunities to explore and discuss these issues early.
RCN Research Institute research programme

The RCN Research Institute, which is based in the Warwick Medical School at the University of Warwick, has developed a significant programme of research focusing on PPI in research and social care services, and experiences of care. The RCN Research Institute collaborates with a variety of patients, carers, nurses and academics nationally and internationally on a range of projects, and the work is led by Dr Sophie Staniszewska.

This Programme has focused on the development of a PPI evidence base and how this informs best practice. For example, RCN Research Institute has undertaken a number of systematic reviews to examine the conceptualisation, measurement, impact and outcomes of patient and public involvement in research (Brett et al 2014, Brett et al 2012), services (Mockford et al 2012) and have used these reviews to develop guidance for the reporting of PPI, in order to enhance the quality and transparency of the evidence base through the development of the GRIPP checklist (Staniszewska et al 2011b).

Dr Staniszewska has also been part of key studies developing our understanding of PPI in more depth (Mathie et al 2014) and in specific areas such as palliative care (Hunt et al 2013), surgery (Jones et al 2014) and neonatal care (Staniszewska et al 2012c, Brett et al 2011). She has been involved in studies examining how effectively PPI has been operationalised within the CLAHRCs initiative (Rycroft-Malone et al 2013) and is now PPI research theme lead in CLAHRC West Midlands. Studies such as the POPPY project have focused on areas of importance to patients (Staniszewska et al 2012c, Brett et al 2011) and influence policy makers nationally and internationally (such as the Department of Health Neonatal Toolkit (2012) and UNICEF Quality Standards).

Dr Staniszewska has also led on the development of new areas, such as the potential for public involvement in the development of patient reported outcomes (Staniszewska et al 2012e) and the need for public involvement in the field of research implementation (Staniszewska et al 2013a). The recently completed GRIPP 2 study involved working closely with the EQUATOR network at the University of Oxford, which has developed international guidance for the reporting of patient and public involvement.

Dr Staniszewska has influenced strategic thinking, working closely with Simon Denegri, NIHR Director of Patient Engagement and Participation to identify key challenges for the future (Staniszewska and Denegri 2013). She co-chairs the Methods and Impact sub-group of the Citizen and Patient Involvement Special Interest Group of Health Technology International, focusing on the development of patient involvement in technology evaluation internationally. Dr Staniszewska is also Vice-Chair of the NIHR Breaking Boundaries Review, launched earlier this year by Professor Dame Sally Davies, tasked with developing a strengthened vision of patient and public involvement for research, which will be launched in November 2014. She works closely with funders, including NETSCC to ensure PPI is embedded into research funding processes. In addition, she is a member of the HEFCE Health Services, Primary care and Public Health Panel, particularly focusing on impact and public engagement with research.

In relation to patient experience, Dr Staniszewska has carried out a number of studies in fields such as neonatal care (Staniszewska et al 2012c, Brett et al 2012), Chronic Fatigue Syndrome / Myalgic Encephalomyelitis (Staniszewska et al 2010, Haywood et al 2011). More recently she developed the Warwick Patient Experience Framework (Staniszewska et al 2014, O’Flynn and Staniszewska 2012) which underpinned the development of the NICE Guidance for Patient Experience.
This year Dr Staniszewska has chaired the NICE Evidence Update for the Patient Experience Guidance (2014) and is a member of the National Quality Board Patient Experience Sub-group as academic advisor.

**RCN Nursing Team specialist adviser activities**

The RCN is committed to maximising the potential for patients and carers to influence the education and practice of healthcare professionals by establishing clear mechanisms of communication between patients and carers and professionals. The involvement of patients, carers and the public in health decision-making and self-care is core to the UK’s National Health Service, fundamental to quality care and is made explicit in the RCN’s *Principles of Nursing Practice* (RCN, 2014d; Principle D).

The RCN Nursing Team of specialist advisers lead nationally on clinical and professional nursing issues across the lifespan, in all specialities and in all settings. Advisers in all areas of specialty are pro-active in facilitating PPI in education and training activities. Examples of activities are provided below, together with observations on any key messages in particular areas.

*Children and Young People’s Services:*

The RCN has worked closely with the RCPCH parents and carers group, as well as the RCPCH young people’s council, and bodies such as the National Children’s Bureau, and more recently NHS England to ensure children and young people’s voice is heard and active participation in both service design and education/training of health care staff.

Recently the RCN adviser in children and young people’s nursing participated in *The Big Discussion* where children and young people highlighted what mattered to them and issues related to the education and preparation of health care staff (Birmingham Children’s Hospital, 2014).

There are further key messages for PPI in Children and Young People’s Services. In order to maximise the potential for children and young people to influence the education and practice of healthcare professionals clear mechanisms of communication between children and young people and professionals need to be established. Forums already exists which can inform HEE in its work, including the independent forum which advises the Secretary of State for Health on children and young people’s issues (The RCN Adviser for Children and Young People’s Services is joint lead for workforce and education on this forum). Finally, there are specific sub topics which need special consideration; such as, the involvement of children, young people and carers in both physical and mental health education and practice.

*Criminal Justice:*

The RCNs approach to service user and carer involvement in Criminal Justice Nursing takes a product / service development approach, where the service user or carer is the principle stakeholder. This approach is taken internally when developing our own resources and externally when working in the intercollegiate / interagency environment.

The RCN has developed *Principles for Nursing in Criminal Justice* (RCN, 2014e), including and involving people in prison as key stakeholders in this work. Because those in contact with the criminal justice system understand their needs best, their involvement as key stakeholders allows service specifications to be defined, and therefore workforce models to be designed and education to be commissioned. It is important that this involvement is not
ad hoc or in response to the need for input at a specific time, but rather an ongoing process at provider level.

Mental Health:

The RCN was widely recognised for its leadership and their work with the Department of Health on the *Positive and Safe programme* (Department of Health, 2014a) and the *Helping health and care services manage difficult patient behaviour guidelines* (Department of Health, 2014b) which aim to reduce the physical and psychological harm caused by misuse of restraint. Service users were represented on the steering group and expert reference group for the *Positive and Safe programme* and this invaluable contribution illustrates how service users can directly shape practice and the education required to enable that practice.

There are further key messages for PPI in mental health services. The involvement of service users should take the form of full and equal membership on steering committees. This may be in addition to insights gained for example through focus groups with a wider population of service users, but service users should also have permanent roles on project boards or steering committees with a remit covering nurse education. Planning takes place in education and practice through processes such as meetings. For mental health services users, and indeed for some physical health service users, formal meetings may not be a productive mechanism for engagement and alternatives should be considered. The impact on the individual of participation should be considered and catered to, empowering them to play a full part in education and practice planning.

Public Health:

The RCN take a ‘promote, protect & prevent’ approach to public health, evident in our work on education and our engagement with local communities and institutions. At the University of Hertfordshire, the RCN engaged with service users to validate the content of their post graduate courses in specialist community public health and specialist community nursing. This engagement explored the views of the service users on what they would expect of professionals working in these roles, and the information gained used to form the curricula. The involvement of service users continues in the assessment of students on both pathways.

Care of Older People:

The RCN works with a wide range of agencies, college partners and third sector bodies to ensure that the voice of older people is heard in education and practice. In collaboration with Age UK and other stakeholders and representatives, the RCN has published *Improved hospital care for older people* (RCN, 2012e). This work made a number of recommendations for improvements in training for hospital staff and demonstrations that all hospitals are providing patient centred care.

There are further key messages for PPI in care of older people. Older people are as varied demographically in terms of their health and social care needs as the rest of society. Age alone should not be the sole determinant of a representation of older people in society, but also sex, race, ethnicity sexual orientation, religion and so on. Many agencies, such as the Social Care Institute for Excellence (2014) have resources guiding best practice on involving “seldom heard groups” in care and education planning. The RCN supports the *Quality Mark for Elder Friendly Hospital Wards* (Royal College of Psychiatrists, 2014) which ensures an understanding among staff of basic care needs.
**Dementia:**

The involvement and inclusion of people with dementia and family carers has provided valuable insight into the direct experience of care, enabling developments to be focused, targeted and meaningful. For example, a group of people with dementia, family carers and practitioners were brought together to advise on and support the development of the *Triangle of Care model* (RCN, 2014b) to facilitate more inclusive and supportive approaches to care. This model requires investments in training and education, with expected benefits including improved patient outcomes, decreased admission rates and reduced lengths of stay.

**Long term conditions:**

The RCN works with a number of patient organisations to understand issues relating to education and training for long term conditions and how these issues can be linked to RCN policy. The RCN is also a member of the Coalition for Collaborative Care which is working with patient organisations, patient representatives, National Voices and others to identify how best to implement shared decision making and care planning that is patient led in order to manage their long term care more effectively.

Our main focus for long term conditions going forward will be end of life care. This work will involve gathering the views and lived experiences of service users and RCN members to ensure that the workforce is educated and skilled in the care of those approaching the end of their life.

There are further key messages for PPI in long term conditions. The involvement of those living with long term conditions in planning for the education of the future nursing workforce is vital, particularly given the growing burden of long term conditions including endocrine, neurological and musculoskeletal. The views of both those self managing as well as careers are important, particularly as the acute sector continues to shrink in size and will not exist as a care boundary post integration.

**Midwifery and Women’s Health:**

The current focus for the RCN Adviser in Midwifery and Women’s Health has been the eradication of female genital mutilation (FGM). Working closely with women’s groups, human rights groups and other Royal Colleges, the *Tackling FGM in the UK* (Royal College of Midwives, 2013) report was produced in collaboration with key stakeholders which included victims and those campaigning on behalf of victims. Key to the successful eradication of this practice is using the insight of victims to educate the wider workforce on how to identify FGM and how to intervene.

Midwifery and the RCN have a long history of engaging with mothers groups that lobby for improved maternity services. We engage regularly with organisations such as the National Childbirth Trust (NCT) and other women centred organisations. The NCT have worked collaboratively to produce educational resources for professionals and parenting educators.

Collaboration with third sector organisations that focus on fertility, pregnancy, childbirth and women’s health is particularly valuable, as it focuses on women and has the potential to enhance the wider family health and well being. The RCN is currently developing standards for the Clinical Nurse Specialist in Endometriosis and a Factsheet for nurses working in this area. The project is in collaboration with Endometriosis UK, whose vision is to improve the lives of people affected by endometriosis and work towards a future where it has the least possible impact on those living with the condition. The RCN vision includes enhancing
nurses’ skills to provide care for women suffering with endometriosis to the best quality possible.

**Acute, Emergency and Critical Care:**

The RCN are currently part of the NHS England steering committee for the ongoing national review of urgent and emergency care. This review has recognised that the current model of urgent care is unsustainable as is the workforce model in use. The RCN Adviser for Acute, Emergency & Critical Care is working with an intercollegiate group to examine how the workforce model can be future proofed.

Critically, this work suggests that the perception among the public about what nurses and HCAs do in urgent care is preventing the potential of the nursing workforce from being unlocked. The public have varied views about the nurse as lead clinical, despite the directory of ambulatory emergency care identifying multiple conditions which are managed from presentation to discharge by nurses. It is important to engage with the public over the coming years so their expectation is to see a professional who is trained to treat their presenting condition, not an expectation to see a physician or other specific professional.

The way in which unscheduled need is catered to is changing and this has implications for the skill mix and profile of nurses in urgent and emergency care. There are increasing numbers of nurses in the pre-hospital and inter-hospital space, and nurses are moving into ambulance services as paramedics move into the Emergency Departments. The emergence of co-located emergency and urgent care has blurred boundaries between emergency nursing, primary care nursing and practice nursing.

The RCN in partnership with NHS England and others have been involving patients groups to develop messages that keep the public informed and gain feedback on what they want in response to unscheduled need, an accident or an emergency – and, crucially, what skills they expect of those responding. This in turn has raised the complex issue of traditional legacy values, compassionate care, and clinical/technical competence in a high technology, high intervention discipline.

The range of skills needed to deal with the undifferentiated nature of unscheduled need require a broad understanding of medical and long terms conditions, trauma and minor injuries as well as care across the lifespan. In recognition of this, RCN is working to produce an integrated national career and competency framework for emergency care which will have components each for HCAs, Nurses, Emergency Nurses and advanced nursing roles in emergency care (Emergency Nurse Practitioner, Nurse Consultant and Advanced Care Practitioner).

To address the service users concern about safety and confidence, we are working with the College of Emergency Medicine and HEE to ensure that advanced nursing roles and emergency physician roles use the same set of competencies and assessments.

**National PPI work across RCN**

There are further examples of PPI activities across the RCN nationally. For example, RCN Northern Ireland has service user involvement in a variety of programme, including a one day patient safety programme aimed at senior managers, a one day and half day programme on Fundamentals of care aimed at Health Care Assistants (HCAs), and a half day programme for GP employed nurses. Ulster and Queens Universities include service users in the delivery of their nursing programmes. The protocols used by Queen’s and Ulster University serve as an illustration of good practice in relation to patient involvement in
programmes. Chief Nursing Officer in Northern Ireland has Policy responsibility for patient and client experience. The Department of Health Social Services and Public Safety NI (DHSSPSNI) has Patient and Client Experience Standards and an agreed process for monitoring their experience against those standards.

Northern Ireland has a Patient Client Council established in legislation as an independent voice for patients, clients, carers and communities. The Council has a duty to engage with the public, promote involvement of patients, clients, carers and communities, to promote advice and information in the design, planning, commissioning and delivery of health and social care and to provide assistance to individuals making complaints. The Public Health Agency (PHA) has a Deputy Director of Nursing, Patient Experience, Safety and Quality who chairs a regional Patient and Client Experience Steering Group. This Group oversees the implementation of Patient Client Experience policy and standards and makes recommendations for practice. The Director of Nursing and Allied Health Professions PHA has led the implementation of an initiative 10,000 patient voices through which real time stories are collected from patients within the five Health and Social Care Trusts and the community about their experiences of using health and social care services in Northern Ireland.

Themes 2 & 3: Valuing the role of the care assistant; Widening opportunities for care assistants’ career progression, which may include entry to nursing education

For the purpose of presenting a structured description of the issues concerning health care assistant (HCA) education and training, we have conflated themes 2 and 3.

Summary

Valuing the HCA workforce is routed in identifying potential and showing potential in all workers, including involving them in decision making on the future direction of the workforce. This includes widening opportunities for career progression within a national nursing career framework.

Regulation of the HCA workforce can help reduce unnecessary variation in training and development, but would require consensus on the knowledge, skills and competences HCAs require. Education and training provided to meet requirements needs formal and robust evaluation in order to determine the most effective approaches to delivery, understand translation of learning into practice, and demonstrate improved outcomes for staff and patients.

Engagement and career progression

Just as patients and the public should be involved in decisions about the future of healthcare, so should healthcare assistants (HCAs) be involved in decisions on the future direction of their workforce. Not only does this demonstrate placing value in HCAs, but by ignoring the views of HCAs and nurses, we risk undermining the legitimacy of reforms and the impact of intended outcomes. The foundation for appreciating HCAs must therefore be the desire to identify potential in every worker and have confidence in their ability to add essential value to the future healthcare landscape.
However, it is not enough to merely identify the wealth of untapped potential in the HCA workforce. We must also promote further training and education programmes and widen opportunities for career progression. This requires buy-in at multiple levels, from the organisation as a whole through to the line-manager, and it is also impacted by wider policy initiatives (for example, apprenticeships). Indeed, line-manager buy-in is particularly required in order to offer career plans, development and guidance.

Promoting and improving education and training that lies within a framework of HCA career progression, such as continuing professional development (CPD) and training specific to the role of the HCA, is key to enabling more seamless progression route for the healthcare workforce.

For example, the RCN has developed an online learning resource for nurses at all levels, including HCAs, called *Diabetes Essentials* (RCN, 2014b). The resource helps to maximise the potential of the HCA workforce to impact positively on patient outcomes and experience through specific, targeted CPD relevant to their specialist area of practice. This approach to continuing education and speciality was also used by the RCN Perioperative Forum who worked with the periopertaive care collaborative to showcase and maximise the role of the support worker in the operating theatre environment (Perioperative Care Collaboration, 2007).

Promotion of education and training should be supplemented with initiatives to increase opportunities for career progression. Whilst there are an increasing variety of roles for HCAs available across the range of healthcare specialities and the lifespan of the population, these roles have developed at local level in response to operational needs and tend to be technically based (for example, plaster technicians in emergency departments, the visual fields technician in the eye hospital). Though technical roles are enjoyed by many and are successful operationally, there are continued issues with nomenclature, regional and national inconsistency and support for the individuals undertaking the associated education and practice. A range of opportunities that include the fundamental care provision role, technical roles and progression to registered nursing which are nationally recognisable will allow the necessary support structures to be established by higher education institutions (HEIs) and providers.

A good example of widening opportunities for career progression comes from the University of Surrey which mapped their foundation degree in health and social care against the first year of the degree programme to ensure students can progress to ‘level 4’. Some of their foundation degree students secured band 5 posts, undertaking specific projects and taking on higher responsibilities such as Support Manager within the community setting. The University of Surrey encouraged managers to fully commit to tracking the students’ progress and offering career guidance on completion of the foundation degree. When put forward for the foundation degree, future prospects and a development plan were discussed as part of the interview process.

**National and international HCA learning and development**

In Northern Ireland, RCN Learning Representatives carried out a learning needs analysis in 2014 for HCAs in the independent sector to inform the delivery of learning and development programmes. An example of this is a resource on *Improving your English language skills in Health Care settings*, provided in RCN NI for overseas care assistants. There is also a Northern Ireland HCA network by HCAs working in trust, community and independent sector settings. This network hosts educational events, liaises with the national RCN HCA Committee and informs provision of learning and development programmes at the RCN in Northern Ireland. RCN Northern Ireland have been commissioned by the Public Health
Authority to provide *Fundamentals of Care* programmes to 2,000 HCAs working in the Independent Sector; for example one day programmes on Nutrition, Pressure Ulcers and Infection prevention and control.

The Northern Ireland Practice and Education Council (NIPEC) is leading an initiative on *Development of Health Care Support Workers Roles Supporting Nursing*. The aim of the work is to ensure a consistent approach regarding the role, remit, function and education of Health Care Support Workers (HCSW) who undertake delegated aspects of nursing care and are supervised by a registered nurse. Progress to date has seen the development of regional job descriptions for band 2 and 3 nursing HCSWs, and the development of a Code of Conduct for HCSWs.

The Department of Health, Social Services and Public Safety Northern Ireland (DHSSPSNI) commission the Open University to provide a small number of places each year (10-20) for health care support staff to undertake pre-registration Nurse Education programmes in Adult Nursing and Mental Health. These arrangements include providing financial support to Trusts to provide backfill support for HCAs completing these programmes. These have been very successful and require further investment. This approach attracts into the profession those HCAs who have demonstrated in employment, the core values and attributes required to provide nursing care.

The RCN Northern Ireland in partnership with the Open University, has supported a pathway for HCAs who wish to progress to nursing through funding for DHSSPSNI to support 15 students to undertake the Open University K101 programme which gives accreditation equivalent to the first 6 months of the Open University pre-registration nursing degree programme. The Department also funds an Open College Network accredited programme provided by the RCN in Northern Ireland for HCAs and gives participants 9 credits at level 2. This course comprises of 3 modules on communication skills and clinical observations, and it is hoped to further develop this programme.

The Royal College of Nursing in Scotland has designed a development programme *Supporting Better Care*, aimed at nursing and care assistants, Health Care Support Workers and assistant practitioners – wherever they work within either the NHS, independent care sector, charities and private care or voluntary organisations across the whole of Scotland. This is an RCN accredited training programme which is designed to build on the knowledge, skills and confidence of those who provide direct care to patients / clients in any care setting.

The programme has been running since 2008 and is delivered as outreach where RCN trained facilitators support delivery of the programme by going into the commissioning organisation regardless of location. This meets the needs of both employers and staff and the delivery approach is flexible where it can be delivered as either 4 full day sessions or one full-day session and 6 half day sessions. This flexible approach has been invaluable in that it has enabled employers to release their care assistant staff to be able to attend and it increases staff’s access to this learning opportunity.

The programme has been successfully delivered to the island health boards of Orkney and Shetland as well as to a range of organisations from the Highlands to the Borders and across the central belt of Scotland. It is suitable to both those new to their role as care assistants or experienced workers and it is adapted and made bespoke to meet the learning needs of each cohort taking into consideration the context and care setting within which participants are working.

*Supporting Better Care* is designed to support all learning styles and includes a mixture of presentations, interactive workshops and group discussions to enhance the learning experience. Personal reflection on learning is encouraged and participants are given
opportunities to engage in interactive practical sessions which include group work to explore scenarios supported by educational DVDs and the use of specialist resources to experience the patient / client perspective. All sessions are supported by a range of quality assured handout materials which outline best practice / most up to date evidence. There are sessions on communication skills and customer care, nutrition and hydration, dignity, patient safety, sensory impairment, diabetes and dementia awareness. The course focuses on the transferring of learning to the practice setting and is an adjunct to the RCN’s First Steps resource.

Follow up evaluation and feedback from course participants has identified that for some the programme has acted as a catalyst to support exploration of further learning opportunities, especially those who had not undertaken any further study or development for many years. This has included looking at pathways including access to nursing programmes, by undertaking ‘HNC in Care’ courses at local further education colleges which can enable them to transition into year 2 of pre registration nursing programmes delivered by local HEI providers.

The Supporting Better Care course acts as a precursor to further education and participation is further enabled in that for RCN members it is free. Help with funding for some self-funded participants can also be available through the Individual Learning Account (ILA). Discounted price is also available to organisations that support participants through the full programme. Organisations are also not charged for individuals who join the RCN within 2 weeks of undertaking the programme. The course is therefore much more affordable and again flexible to accommodate individual and organizational requirements.

In Wales, health care support workers are supported by a voluntary code of conduct (NHS Wales, 2011a) in conjunction with a code of practice for NHS Wales employers (NHS Wales, 2011b). These codes are both aimed providing an assurance framework for patient safety, public protection and supporting healthcare support workers in understanding what is expected in terms of practice.

An NHS Wales Skills and Career Development Framework for health care support workers is in its final stage of development. The aim of the framework is to provide a governance mechanism to inform the skills and career development of the HCSW workforce in NHS Wales. The framework consists of 9 different levels and is aimed at enabling greater flexibility and transferability within the workforce, along with providing a common currency in evidencing competence through portfolio. The NHS Wales Skills and Career Development Framework focuses on levels 2 to 4 of the Skills for Health Framework. The Qualifications and Credit Framework (QCF) has been inbuilt to the Framework. The Framework currently applies solely to Healthcare Support workers employed within the NHS in Wales, and the RCN actively promotes the opportunity for all Healthcare Support Workers to benefit from the Framework, irrespective of employer.

From an international perspective, Finland is one of the few countries which the European Commission identified as providing vertical career development opportunities for HCAs to enter the nursing profession. Currently, HCAs in universities can undertake nursing studies at universities and polytechnics, or alternatively, they can submit evidence that their practical experience to-date counts towards their nurse education (fitting with the UK approach for Accreditation of Prior Learning – see our discussion under theme 4 below). For the university route, around 20 per cent of nursing students are HCAs.
Evaluating learning interventions

Investing in improving the quality and promotion of training and development is crucial if we are to develop a workforce that has the right skill mix to meet future challenges. Training programmes have been associated with a number of desired benefits. Griffin et al (2012) evaluated a six-month assignment and mentor-guided HCA development programme introduced by the Belfast Health and Social Care Trust and found that it was associated with improved confidence and team working skills. A study by Brown et al (2013) found that training for HCAs was associated with reduced staff turnover rates and improved clinical outcomes although the nature of this training was specialised rather than foundational. In one brief review, Griffin and Blunt (2011) also suggested that training HCAs to NVQ Level 3 led to HCAs taking more responsibility. This in turn freed up nursing time and gave nurses confidence in delegating tasks to HCAs. HCAs also felt empowered to give information to patients (Griffin and Blunt, 2011).

Other examples of training include specialised HCA schemes developed to enable HCAs to deliver effective palliative care (Marie Curie Cancer Care, 2012), programmes developed to improve dementia care (Board, 2012), educational programmes to develop HCAs who work in children’s palliative care (Crighton, 2012) and programmes to train HCAs to become assistant practitioners in a chemotherapy day unit (McGowan, 2010). Whilst these provide good examples of the training programmes available, the heterogeneous nature of most training courses means that it is difficult to generalise lessons learned. Indeed, Cavendish and others noted that though HCAs make up a significant proportion of the UK health care workforce, the confusing multitude of local basic training and educational programmes for HCAs was unconducive to delivering high quality patient care, quality assurance and role identity (McKenna et al, 2005; Spilsbury et al, 2010; Cavendish 2013).

There is a pressing need for more research on the impact and effectiveness of HCA training schemes on a variety of outcome relating to delivery of care. The RCN’s First Steps learning resource and the First Steps Impact Evaluation research project being undertaken by the RCN is contributing to our understanding of this situation. First Steps is an online interactive learning resource developed and launched by the Royal College of Nursing (RCN) in 2011 that supports HCAs to acquire the fundamental skills, values and principles that underpin their role, something that has been strongly recommended (Francis, 2013; Cavendish, 2013; Griffin, 2013). First Steps has been widely used, and RCN’s stride to increase access to the resource has meant that the number of monthly sessions has increased from 3,155 in March 2013 to 10,488 in March 2014. The impact of First Steps is currently being evaluated, the results of which will be disseminated in early 2015.

Despite the need for more research, there is little point in promoting and investing in training and education if it is not supplemented by policies and initiatives that widen access to that very training and education.

A good example is found in South Africa, where the ‘Practical Approach to Care Kit’ (PACK) aims to equip nurses and HCAs to diagnose and manage common adult conditions at primary care level. It includes information on symptoms, clinical evidence, policy-based guidelines and training which nurses and HCAs can keep on their person. Importantly, PACK has helped South Africa to mitigate the challenge of HCAs not being able to secure sufficient time from employers to refresh their key skills and knowledge. At the present time, trials are being undertaken to upload PACK guidelines onto smart phones and tablets in order to further improve accessibility (University of Cape Town, 2014).
Training and regulation

Identifying, utilising and maximising the potential of the HCAs will be significantly strengthened by reforming the accountability mechanisms for the training and regulation of the HCA workforce. This will be in keeping with the international recognition and trend in regulating the HCA workforce. For example, in the United States 75 hours of approved training is required, for those HCAs (Nursing Assistants) who want to attain a Certificate 111 and enter onto the federal voluntary registration system (doing so will improve their career progression opportunities but this is not mandatory). This rises to one year of pre-registration training in Brazil and Germany and two years training Japan. It should be noted that the focus across these examples is on pre-registration education, and that formalised post-registration CPD is almost entirely absent, leading to potentially weaker career progression opportunities.

A 2009 study initiated by the European Commission (EC) mapped the regulatory approach towards HCAs of 15 countries, including the UK (European Commission, 2009). The report found that the UK is one of only three countries (together with Ireland and Switzerland) which do not have some form of regulatory system for HCAs. In Austria, Bulgaria, the Czech Republic, Denmark, Finland, Italy and Slovenia, the occupational group (work tasks and duties) of healthcare assistants as well as their education were all regulated. This regulation is also coupled with a legal requirement to obtain a licence to practise after finishing initial education and training. Crucially, the report also found that the UK was exceptional in that it had no official curriculum for HCA education and training.

A 2006 focus paper (Thunborg, 2009) on the experience of HCAs in Sweden, where there is no formal regulatory structure for HCAs, concluded that key motivational incentives which drive other professionals to seek education and career advancement were seriously lacking and that this was compounded by a widespread sense within the profession that they were at the bottom of a tall and complex medical pyramid with little opportunity or support to develop.

Regulation may serve as a mechanism to improve career progression of HCAs. For example, in the United States, the voluntary regulation of Nursing Assistants (the lower grade equivalent of HCAs) has improved scope for specialisation and career advancement for those who choose to undertake completion of Certificate 111 (enabling them to move up to the level of a Licensed Practitioner Nurse – the higher grade of HCAs) (Kessler et al, 2012). Non-holders of this certificate, although allowed to practice, are legally restricted to a much narrower set of patient responsibilities which can have a knock-on effect for their career development options.

Regulation may help reduce the unnecessary variation in HCA training and development mentioned above. This issue was also highlighted in the Francis Inquiry, where national standards of training for HCAs were recommended (Francis, 2013: recommendation 211, p.107). Reinforcing this recommendation, the Cavendish Review (2013) recommended that all HCAs should undergo a standardised fundamental training programme that is based on current best care. This recommendation has been taken up by the Government and Health Education England (HEE) has been tasked with developing the Care Certificate which will be implemented from March 2015 in England, although the framework for quality assurance is currently underdeveloped. The other UK countries have also established codes and standards for health care support workers in different formats.

To regulate the HCA workforce, there is a need to understand and come to a consensus on the skills and competencies HCAs require to deliver effective care and add value to the healthcare system. Regulation that is underpinned by such a consensus can give clarity and confidence to the delegation of activities from nurses to HCAs, which will be required in the
future as nurses take on increasingly complex roles. Delegation of activities to HCAs has been shown to help HCAs develop new skills and specialisms, and conversely in countries without a system of regulating HCAs delegation has proven more problematic.

Finland provides a case study where the HCA profession is not just regulated but the title and competencies of ‘Practical Nurse’ are formally protected, enabling HCAs to achieve much greater workplace autonomy. This appears to have delivered a significant boost to morale, retention and recruitment (European Commission, 2009). However, the implications for this within the UK context would need to recognise the historical background surrounding regulation of a second level nurse and the decisions to discontinue this route in the 1990s.

The natural progression for understanding core skills, competencies and capabilities will be to set these out in a cohesive, nationally agreed career framework. At a time of financial constraints, employers may seek to provide or fund the cheapest – rather than the best or best value – learning options. A career framework, linked to regulation, will help ensure minimum standards for quality are met and that the HCA and nursing workforce are able to meet the emerging challenges in the next 10 to 15 years.

The European Union

Within the European Union (EU) there is a certain level of harmonisation for roles equivalent to the ‘general care nurse’. This applies to the content of the pre-registration curriculum and time study requirements. This is anchored within EU legislation. It is important to note that in the UK, the general care nurse role crosses over only to the RN Adult Nurse position.

The next step is to look at common education competencies. The RCN is currently involved with its partners within the European Federation of Nurses’ Associations (EFN) in looking at a competency framework for general care nurses across Europe.

With regards to HCAs, the RCN’s position is that a clear and consistent system for the education and management of the HCA role within the nursing team across the EU is needed. However the RCN is conscious that member states are at very different stages in relation to the education and training of healthcare assistants and the regulation and registrations of them. There will need to be extensive consultation with nursing groups going forward to ensure any future system of professional mobility for HCAs is effective and which avoids any detrimental implications with wider consequences for nursing across Europe.

Theme 4: Assuring flexibility in nursing and care assistant education and training of the future

Summary

Future models or frameworks for CPD need to be responsive to differing needs of the nursing workforce, particularly variations in access to support and development across different groups. To best achieve flexibility, there is first a need for consistency: in the terms used within and about nurse education; in the approaches taken to support career progression through accreditation of prior learning; and in ensuring a broader and more robust evidence base is developed to understand how models of clinical placement provision impact students’ knowledge and skills development, confidence to practice in a range of settings, as well as influencing their future career choices.
Common understanding of terms

There is a need for clarity and collective understanding of terms that are used to describe education and training. There is currently some confusion as to how terms encapsulate ambitions or define boundaries around particular types of education and training. The following discussion provides some examples of definitions for terms and how their interpretation may be problematic.

Competencies and capabilities

Competencies: “What individuals know or are able to do in terms of knowledge, skills, attitudes.” (Fraser and Greenlaugh, 2001)

Capabilities: “Extent to which individuals can adapt to change, generate new knowledge, and continue to improve their performance” (Fraser and Greenlaugh, 2001)

There is an emerging debate within health education around the value of competencies versus capabilities. There is no one agreed definition of competency, but capability is believed to better indicate the need for transformational learning if staff are to work effectively in unfamiliar contexts.

“Competency may not in fact be a helpful term. To some extent it perpetuates the notion of a minimum standards culture without aspirations for excellence.” (General Medical Council, 2013)

It is argued that competency does not necessarily imply that ability to transfer learning – a requirement for future flexible working approaches. Development of curricula based on professional capabilities will enable a better focus on outcomes rather than content and a greater emphasis on professional behaviours and practice.

There is a need for debate across the health professions about how these terms encapsulate what health curricula are seeking to achieve.

Statutory and mandatory training

Statutory Training: “Statutory training is that which an organisation is legally required to provide as defined by law or where a statutory body has instructed organisations to provide training on the basis of legislation.” (RCN, 2009b)

Mandatory Training: “Mandatory training is that determined essential by an organisation for the safe and efficient running in order to reduce organisational risks and comply with policies, government guidelines. Essential or compulsory are also terms used to describe mandatory training. Some organisation use mandatory training as a ‘catch all’ to cover mandatory and statutory.” (RCN, 2009b)

Whilst these definitions appear to offer clear boundaries around the extent and scope of this type of training, in reality it is often confused with continuous professional development activities.

Continuous professional development and lifelong learning

Continuous Professional Development (CPD): The NMC Prep standards do not offer a definition of CPD but indicate expectations as, “The learning activity which you undertake to meet this standard must be relevant to your practice.” (NMC, 2011)
In a joint statement, the healthcare professional bodies identify that CPD is central to the development of health professionals and is also the mechanism for the identification, development and maintenance of high quality care (RCN, 2007b). It can include both formal and informal learning activities, with identifiable learning outcomes, but excludes mandatory or statutory training. However, registrants do use mandatory and statutory training activities to evidence meeting the PREP requirements, reflecting that these can have relevance for their practice.

Further clarity is required and clear guidance will need to be offered to support implementation of the revalidation model.

_Lifelong learning:_ The National Institute for Adult Lifelong learning (NIACE) offer useful insight into this term. It can incorporate both formal and informal learning, where the former occurs in structured, organised contexts rather than the unplanned learning that occurs in everyday contexts, but more work is required to understand the relationships between these different types of learning (Beer, 2007).

**Future considerations**

The development of any future model for education and training for nursing and care assistants will need to take account of and allow for demographic profile of the profession itself.

A recent RCN report on _Safe Staffing Levels_ (RCN, 2013a) identifies the ageing profile of the profession as a major concern for nursing:

_In 2012, almost 50 per cent of the workforce was aged 45 or older, compared to 33 per cent in 2002. The community nursing profile is markedly older. Almost 50 percent of NHS community nurses in NHS Scotland are aged 50 or older, with a similar pattern in the other UK countries. This means that the replacement challenge of dealing with a high and growing incidence of retirements will be most pronounced in the community sector — the very sector earmarked by policymakers as the priority focus for NHS service changes._

(RCN, 2013a; p.14-15)

A report by Pike et al (2011) specifies that a higher proportion of older nurses work in the NHS community, GP practice, independent care home, hospice and agency setting, indicating the importance of taking a flexible approach to professional support and development for this staff group. Pike at al (2011) also acknowledge research findings suggesting that older nurses experience more difficulty accessing CPD opportunities than younger nurses, and are less likely to have academic qualifications than younger nurses, the latter being a potential barrier to accessing development opportunities. We are also made aware of these issues through our members, these being raised in a resolution to Congress in 2011 focusing on concerns around access to post registration degree level qualifications for non graduate nurses. (The resolution was passed with 95% agreement.)

The UK has a diverse nursing workforce, including those who are recruited from EU and international countries. These staff offer a valued contribution to health care but their CPD needs may not always align with those who have been educated within the UK. Research has indicated that they are not always supported to achieve their full potential and they often

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suffer from career stagnation (Smith et al, 2007). The programme of work being undertaken for HEE by Health Education North Central and East London (HENCEL) to address the needs of internationally educated nurses is welcomed.

Given this scenario, there is a need for any future model or framework of CPD to be responsive to different needs of the nursing workforce.

**Accreditation of prior learning**

One area in need of further development is around accreditation of prior learning (APL). Within the current approach higher education allows provision for applicants to courses to have their previous learning recognised. This may be through accreditation of prior certificated learning (APCL) or accreditation of prior experiential learning (APEL). While APCL is a more straightforward process than APEL, we’d suggest that it is the experiential learning element that many experienced nurses will wish to have recognised.

NMC *Standards for pre-Registration nursing* (NMC, 2010) currently allow up to 50% of a programme to be achieved using the approved HEI’s APL framework (referred to as recognition of prior learning (RPL) in Scotland). However, there is no consistent approach as to how this is implemented. All universities set their own APL framework, and there are variations in the amount of APL allowed and how this can be demonstrated.

There is a need for a more consistent approach for APL for pre and post registration programmes, together with further work to understand and promote innovations and best practice in this area.

**Practice placements**

Our members report continued concerns around clinical placement provision, attributing this to limitations around availability of suitable placements, particularly outside of hospital based provision, and the constraints in resources required to identify and open up new and less traditional practice placements. A number of HEIs now use a ‘hub and spoke’ model for placements, and this is explained in work exploring this model undertaken in Scotland, along with some of the challenges this approach posed (Roxburgh, Bradley and Lauder, 2011). However, there is a lack of understanding as to how this model impacts on student’s knowledge and skills development, or impacts their future career choices.

There needs to be better alignment with pre-registration programmes and the public health agenda. A stakeholder event held by the RCN (RCN, 2014a) highlighted issues of concern, particularly a focus on acute hospital care within most pre-registration education programmes. We are taking forward the action plan arising from this event.

It is interesting to note the development of an NMC approved pre-registration programme with a public health focus (where two-thirds of the placements are in community settings) developed at the University of Lincoln (2014). This approach offers a different curriculum model, and there is considerable value in this being formally evaluated for its impact on future practice and career development.

Whilst pre-registration programmes should equip students to feel confident to practice in a range of settings, there is anecdotal evidence that this is not translating into reality. There appears to be an expectation amongst students that their first post qualifying post will be undertaken within an acute hospital setting, although whether this expectation differs across the fields of nursing warrants further exploration. Our members tell us that there is still a
culture of gate keeping around where newly registered nurses can commence their careers; they report being expected to consolidate their skills in less specialist areas prior to applying to the community or what is considered more highly technical areas, such as critical care.

A means to overcome this issue would be through a well developed induction and preceptorship programme supporting newly registered nurses’ transition into their role (see theme 5), together with an outcomes-based career framework that enables staff to map learning opportunities against competencies and capabilities.

Mechanisms for delivery

Our student committee has raised questions around how skills are identified for inclusion within pre-registration programmes, identifying a wide variation in the range of skills taught within programmes, with the result that students conclude their training with differing skills sets.

There is a need for further, more robust research in this area. There is a lack of understanding from literature exploring this aspect of curriculum development in nursing or how the skills set required at registration is evolving to meet the changing role of the nurse across different fields. Whilst simulation activities have changed approaches to skills teaching, they are not standardised in their use and remain under researched (Ricketts, 2011).

A recent think tank report from the student members group of the Royal Society of Medicine (RSM), undertaken as an interprofessional collaboration with other healthcare student groups, offers some insightful recommendations around care in the undergraduate curriculum (Cork, 2014). They advocate the need for cultural change to combat the lack of shared interaction and learning at undergraduate level using a range of learning and social activities. They also suggest that an ethos of shared responsibility for fundamentals of care should be formalised through teaching and assessment of these skills in all undergraduate curricula.

International evidence suggests that the effectiveness of continuing education is enhanced when a variety of different learning vehicles (including online learning modules, mentoring and workshops) are recognised. However, research into educational systems from Australia and Norway (Charles and Mamary, 2002) has highlighted the risk that employers and providers can misuse this breadth of recognition to focus on the cheapest learning options (such as e-learning and internet modules).

There are known challenges around transference of knowledge into practice. The RCN’s Knowledge and Innovation Action Plan (RCN, 2014b) is a key part of our strategy to help us to address this. There is a need for accessible resources which enable immediate meaningful translation of knowledge into practice. The importance of technology enhanced learning in removing barriers to learning needs to be better understood. There has been a rapid growth in mobile technologies and how these are used for knowledge management. We know that the majority of nurses and midwives use their phones for work purposes (RCN 2012f) and we also know that 25% of users access our ‘First Steps’ resource using mobile devices. Future learning developments thus need to be responsive to mobile technologies and we are planning to develop our future online learning offer to reflect this.

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2 An RCN Congress agenda item from 2012 discussing this issue is available online at: http://www.rcn.org.uk/newsevents/congress/2012/submit_an_agenda_item/23_preceptorship_-_in_the_community (accessed 28 August 2014)
This reinforces the need to ensure that nurses and HCAs are regularly consulted on the quality and relevance of the learning activities and CPD being provided to them through robust evaluation and feedback mechanisms.

An important component of delivering flexible, transferable skills is to allow nursing staff to self-identify their future learning needs. A number of Canada’s provinces have pioneered regulatory systems requiring nurses to reflect on what their specific future learning needs are and how these should be met. The amount of time spent on learning-related activities is then the responsibility of each nurse who must then (as part of revalidation) evidence to the regulator how they have met the learning objectives identified. Feedback provided to the RCN by nursing associations, trade unions and regulatory bodies within Canada indicates that this self-reflective approach towards identifying educational needs enjoys strong support among nurses, the public and political leaders.

We believe that the RCN Principles of Nursing Practice (RCN, 2014d) offer a robust framework for nurses to map how their CPD can meet role revalidation within the UK. The eight Principles, whose development included patient and service user organisations, set out what everyone can expect from nursing, emphasising the importance of safe, effective and patient-centred care. They reflect the 6 C’s framework but were developed for use across the four countries of the UK. They also offer a framework against which HCA development activities could be mapped. The Principles of Nursing Practice are provided in appendix 2 of this document.

**Theme 5: Assuring high quality practice learning environments which support the development of the future workforce**

**Summary**

There is a need for a well developed, implemented and evaluated / researched preceptorship programme supporting newly registered nurses’ transition into their role, together with an outcomes-based career framework that enables staff to map learning opportunities against competencies and capabilities.

The RCN is planning work to explore and develop this evidence base and review and refresh our current provision of resources supporting students and their mentors. We are also undertaking a programme of work to investigate the importance and application of specialist nurses and nurses working at advanced practice level in formal and informal educational contexts.

Nurses acting in leadership roles and acting as role models play an important part in ensuring a flexible and high quality learning environment for future education and training needs, although leadership in nursing requires investment in what is currently an unresearched area.

**Mentorship**

As an organisation, the RCN fully accepted the recommendations of the Willis Commission and the recognition that learning in practice is central in learning to nurse. In our response to the Francis enquiry (RCN, 2012a) we state:
We must continually evaluate the success of mentorship and preceptorship experiences, which are vital to the development of future nurses. While not addressed directly by the inquiry report, the quality of practice placements, the relationships between providers of care services and higher education institutions, and the degree to which employers support lifelong learning are all essential contributing factors towards producing a skilled, motivated and valued workforce. (RCN, 2012a; p.4)

This view is reflected in our members’ concerns. At Congress in 2013, one of the resolutions was “That this meeting of RCN Congress urges Council to lobby for all mentors to have protected time, as is standard across other professions” (The resolution was overwhelmingly endorsed: 98.35%)³.

We recognise that achieving change is not without its challenges. In technical reports authored by the RCN for the first Willis Commission on mentoring and preceptorship in pre-registration nurse education (Chandan and Watts, 2012; Currie and Watts, 2012), we reported a lack of robust evaluation into the effectiveness of mentoring or preceptorship in the nursing student context. The role of the mentor and preceptor were not universally and clearly defined, despite being complex functions requiring structured support and training.

This scenario is complicated by a rapidly changing political and policy landscape of healthcare impacts on funding decisions related to education and training, and the subsequent ability of staff to lead, support and develop the future workforce. The development of a workforce that can meet the future needs of the service requires more diverse practice learning opportunities which enable knowledge and skills development for integrated care (HEE, 2013).

The RCN currently has two toolkits available which address mentorship issues, targeted at mentors and students respectively: Guidance for mentors of nursing students and midwives (RCN, 2007a) and Helping students get the best from their practice placements (RCN, 2006a). Both are available as open source resources. These toolkits reflect the requirements laid out in the NMC Standards to support learning and assessment in practice (NMC, 2008). Our intention is to review and refresh these toolkits and the outcomes from the Shape of Caring review and the NMC evaluation will inform our approach to that ambition.

The RCN is committed to undertaking further work focused on mentorship and practice based learning to develop an informed response to this agenda, and support fulfilment of our mission to promote excellence in practice. Building on work described above that was undertaken to inform the first Willis Commission, we are commissioning a project which will enable the RCN to develop an informed, evidence-based contribution to current debates around mentorship and practice based learning for nurses. This project will give recommendations for future work to support nursing education in the practice setting. Our student committee have taken an active interest in this work and will contribute to the project through activities undertaken to understand the student perspective.

We are contributing to work on education and training being undertaken regionally, including issues around mentorship such as the Health Education East of England (2014) Review of pre-registration nurse education. We have links to the work piloting new approaches to mentorship through our Education Forum membership. We are aware that debates around

³ An RCN Congress agenda item from 2013 discussing this issue is available online at: https://www.rcn.org.uk/news/events/congress/2013/agenda/21-equity-for-nurse-mentors (accessed 28 August 2014)
mentors have included questions about who should be mentors: whether this is a role for all registered nurses and its relationship to career progression.

We believe that supporting and facilitating the learning and development of student nurses is an integral part of the role of all registered nurses. We would be interested in the evidence base for how the mentorship role might be differentiated in future. We suggest that if the future role evolves to embody different expectations and requirements, it will be important to consider the title for the role. There is currently a range of different terms used for support in practice education (including mentor, preceptor, clinical supervisor, practice educator, practice facilitator), a situation that creates confusion as these descriptors are not used consistently in national and international practice or literature.

It is recognised that HCAs play a role in advising and coaching student nurses in clinical practice, with Hasson et al (2012) examining how this is happening in both formal and informal structures. They acknowledge that further research is required in this area, and recommend that any review of mentorship structures and roles recognise and value the contribution of this staff group, as well as ensuring that they are appropriately trained and supported within an identified remit.

It’s important to acknowledge that there are a number of registered nurses who work with students who qualified in Europe or overseas. Whilst international recruitment has significantly reduced in recent years, EU countries have progressively become a more significant source of nurses (RCN, 2013a). This group of nurses brings a valued wealth of knowledge and skills, but also challenges around how they are inducted and developed to meet the needs of the UK health context. The RCN has anecdotal evidence that the overseas recruitment process does not always address values based recruitment practices and this does not appear to be explicitly addressed in the current HEE Values Based Recruitment project (HEE, 2014). Although this project is focused on NHS experiences in England, we believe there would be value in exploring how values based recruitment should be assessed for EU and international applicants for employment and how this impacts on the practice learning environment.

Preceptorship

The preceptorship experience plays an important role in the socialisation of newly qualified nurses, although there is a need for a greater understanding as to how it is best delivered and, where provision is inconsistent, what the barriers are to implementation.

The NMC first published guidance on the use of preceptorships in 2006, with revisions in 2010/2011. One of the recommendations from the first Willis Commission (2012) was that NMC guidance on preceptorship should be observed across all UK employment settings for nurses. Since the Commission, the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) and the Department of Health, Social Services and Public Safety (DHSSP) has published a new framework for preceptorships (NIPEC & DHSSP, 2013), bringing Northern Ireland in line with the other four UK nations. Scotland introduced a comparable structure in 2010 known as the Flying Start programme (Flying Start NHS, 2010) and many English Trusts have emulated the Scottish model following the Department of Health’s comprehensive preceptorship framework in 2009 (Department of Health, 2009). Health Trusts in Wales continue to utilise preceptorship systems which pre-date the Willis Commission.

Northern Ireland’s new framework follows the Willis recommendation, by providing easy-to-use but comprehensive guidance to help ensure that organisations ensure that preceptees understand the preceptorship process and engage fully with it, that care providers have a
written process / procedure to guide the implementation of preceptorships, and that they have systems in place to track and monitor preceptees, from commencement through to completion of the preceptorship period (NIPEC & DHSSP, 2013).

There is a need for investment in the formal development of the preceptor role itself, including a better understanding of the role, its functions and the skills sets required. It may be that the preceptor is commonly seen as an extension of the mentoring role, although there is research to suggest that preceptorship requires considerable teaching (Hyrkas, 2014) and role modelling that may be unique to the role and its place at the intersection of pre-registration education and socialisation into the nursing profession (Rejon and Watts, 2014).

**Specialist nurses and advanced nursing practice**

Specialist nurses and nurses working at advanced practice level have a key role in the formal and informal education and development of others, particularly other nurses and HCAs. Advanced level practice is firmly grounded in direct care provision or clinical work with patients, families and populations (Department of Health, 2010), and encompasses four key elements of: clinical / direct care practice; leadership and collaborative practice; improving quality and developing practice; and developing self and others. Nurses are commonly working at an advanced practice level in areas such as general practice and community health, acute care, sexual health and mental health (RCN, 2013e). The Department of Health (2010) notes that working at the forefront of their area of practice makes these practitioners ideally placed to identify their own and other’s personal development needs and take action to address them.

Nurses in these roles are central to good outcomes for patients, including self care management, and there is evidence of their contribution to cost effectiveness, improved outcomes and reduced length of stay (TREND-UK, 2014). However the boundaries of professional practice and competence have become blurred as nursing roles, responsibilities and areas of practice have diversified and expanded (Council for Healthcare Regulatory Excellence, 2009). There is inconsistency in the use of the term ‘advanced practice’ and a wide range of roles carry the title ‘nurse specialist’ or ‘advanced practitioner’ (RCN, 2014j). Use of titles by those who have not undergone educational preparation to work safely at an advanced level is of concern. To this end, the RCN has developed competencies for these roles, and offers accreditation of advanced nurse practitioner programmes (RCN, 2012b).

In the UK, there is no title protection for specialist nurses leading to the creation of multiple professional titles and roles which has increased inconsistencies in scope of practice, education and training across hospital providers and higher education institutions, and career progression for clinical nurse specialists. The Scottish Government (2010) suggests consistent benchmarking of these roles at recognised levels of practice in terms of expectations of competence, educational preparation and reward is key to sound governance (Scottish Government, 2010). The Advanced Nursing Practice Toolkit (NHS Scotland, 2008) is a UK wide resource relating to advanced practice intended to enhance the understanding of the advanced nursing practice role, benchmarking the level of practice and its application to specific roles across clinical practice, research, education and leadership.

In exploring the current experience and looking toward the future in District Nursing, the Queens Nursing Institute (2014) describe confusion about job titles in the community, with the majority of respondents to a survey on this issues expressing a preference for the title District Nurse to be restricted to those who hold the District nursing Specialist Practitioner...
Qualification. There is a call for a renewed investment in this qualification, and note that consistent use of title across employers may improve understanding by the general public.

The RCN has recently commenced a programme of work dedicated to specialist nursing and advanced nursing practice, which will investigate and describe the importance of such roles in the formal and informal development of others. This programme builds on work to date dedicated to particular specialisms, such as providing guidance for advanced nursing practice, advanced nurse practitioner programmes and programme accreditation within children's and young people's nursing (RCN, 2014).

Leadership and role models

Nurses acting in leadership roles play an important part in ensuring a flexible and high quality learning environment for future education and training needs. However, leadership in nursing continues to be an under-researched area. The evidence on the effectiveness of developing nursing leadership skills is limited, and suffers from a lack of consensus around what constitutes effective leadership in nursing (Watts and Gordon, 2012). There is a need for leadership skills provision to be evaluated robustly and routinely, both within pre-registration nurse education and throughout the nursing career pathway.

Role models of leadership skills and styles are an important consideration in both formal and informal education of nurses. This is of particular importance in pre-registration education, with student exposure to skilled, positive leadership role-modelling significantly enhancing the learning experience, both in formal learning settings and throughout the professional career (Walker et al, 2011; Cummings et al, 2010; Duffield et al, 2009). There is a need for leadership skills to be embedded across all roles, from HCA onwards, within the context of an overarching career pathway.

The RCN Clinical Leadership Programme, which has been well received to date, is a twelve-month programme of learning to develop transformational leadership behaviours in its participants. The programmes are run in local areas, by local facilitators who have attended a Facilitator Development Programme delivered by the RCN. The Clinical Leadership Programme is currently being reviewed in line with the development of the RCN’s Leadership Strategy, with a view to roll out in 2015.

Experienced nurses are well placed to act as professional role models, with ward sisters being a good example of role models in terms of education and training at ward level, as well as in reflecting the organisational support that is required to facilitate this. The role of the ward sister in education and training is described in Breaking down barriers, driving up standards (2009c). This RCN report recommends that ward sisters become supervisory to shifts in order to enable them to fulfil their ward leadership responsibilities: supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward. The RCN is currently undertaking research on the supervisory role of the ward sister, which will contribute to understanding elements of this role, including the delivery of education and training. This work is due for report in December 2014.

The RCN has also undertaken work, following consultation with our members, focusing on the valuable role of a link nurse in leading on an area of specialist interest at a local clinical level. Link nurses are defined as ‘practising nurses with an expressed interest in a speciality and a formal link to specialist team members’ (MacArthur, 1998; cited in RCN, 2012h). However, this role does not have to be exclusive to nurses and can be expanded to link practitioner. This is a voluntary role which offers a mechanism for professional
development for the individual and supports the dissemination of knowledge and skills to drive up standards in practice. Using the role of the link nurse in infection prevention and control as an example, the RCN has developed a generic role profile and framework, outlining competencies for the role, enabling practices, characteristics of link nurse activity and outcomes for the role (RCN, 2012).

This framework has been adapted to incorporate antimicrobial resistance (AMR) and health care acquired infection (HCAI) within the Public Health England (PHE) Centre Regional HCAI Leads network to enable a structure to be built for networking. The network was devised using the principles outlined within the document to work in community settings. The use of HCAI Champions (instead of “Link Nurses”) enables the role to be used more widely and not restricted to nurses. The framework also assisted staff who were not employed in a hospital / Primary health setting understand how systems within IPC worked therefore was not restricted to HCAI leads. The adapted Framework has offered a number of benefits: it offers evidence for career progression, continuous learning and succession planning; it assists the Champions and leads to develop outcomes and identify areas for inclusion in work plans and appraisal systems; it assists PHE staff in having a greater understanding when advising commissioners and performance managers.

**Theme 6: Assuring predictable and sustainable access to ongoing learning and development for registered nurses**

**Summary**

Together with our stakeholders, the RCN has authored a range of frameworks describing and mapping professional competences, many through RCN member forums and focusing on areas of nursing specialism.

The impact of this work will always be limited and correlate to the good will, or buy in, of regional and local educators and providers. What is needed is a national nursing career framework to ensure a shared expectation by all that a specific nurse, in a specific role needs a specific set of CPD activities.

Future frameworks must explicitly address the range of competencies and capabilities in the nursing workforce. Our members have reported frustration that they cannot access an appropriate academic level of development for some qualifications, with barriers being due to a lack of academic credit to meet threshold criteria set (to move from a certificate to degree level at level 6) or a lack of availability of Master’s level modules (as in mentorship programmes).

There is a lack of explicit provision for level two registered nurses, an example of which is the lack of return to practice programmes for this group. It is important that when scoping the needs of the current and future workforce, the move to an all graduate workforce is acknowledged whilst supporting the diverse needs of all levels of registered nurses.

**A national nursing career framework**

The importance of establishing and implementing a properly resourced national nursing career framework was a key recommendation of the first Willis Commission (2012). The RCN is very supportive of this recommendation and recognises that this is a gap in professional provision for the nursing workforce.
There is evidence of a growing interest within the RCN as to how careers may be developed, although to date much of this work has been predominately addressed through activities of RCN member forums, and it therefore focuses on areas of nursing specialism.

Work undertaken by the RCN Children and Young People’s Acute Care Forum describes *Competence, education and careers in neonatal nursing* (RCN, 2012d). This work builds on work undertaken by the Scottish Neonatal Nurses Group (2005) to outline a UK wide career and education framework for neonatal nurses, and also makes reference to the non-registered workforce. The framework uses Benner’s (1984) work on levels of practice and also aligns to the Skills for Health (2006) Career framework for the NHS.

The RCN Fertility Nursing Forum led the development of *An RCN training and education framework for fertility nursing* (RCN, 2013c). This work provides a clear framework for the training and education of nurses and midwives who are engaged in fertility care, as well as assimilating the information required for providers of fertility services and commissioners to develop education programmes. It also helps to clarify where confusion exists over job titles within fertility services, and sets out a framework for both employers and patients to understand the role and level of education and competence correlating with specific job titles. The framework is beneficial to HCAs in supporting them to enhance their knowledge and skills, and therefore competence. It also benefits practitioners within this specialist field to aspire to particular career levels, supporting them in identifying learning opportunities to meet their role requirements.

The RCN have also worked across the postgraduate practice arena to define the requirement for nurses, in terms of professional competency, to practice at various levels of autonomy in a range of specialties. Our specific work on levels of practice includes, for example, our work on *Integrated core career and competence framework for registered nurses* (RCN, 2009a) and *Advanced Nurse Practitioners* (RCN, 2012b). The RCN has also undertaken research around the role of the nurse consultant, *Becoming and being a nurse consultant: towards greater effectiveness through a programme of support* (Manley and Titchen, 2012). This research examines the developing role of the nurse consultant, exploring how these nurses can further improve their practice and that of their colleagues. Providing a programme of support through action learning, the findings of the study suggests that participants became more effective in their roles, creating recognisable impact and achieving tangible change.

The RCN’s work on specialist postgraduate practice also includes for example: *A competence framework for orthopaedic and trauma practitioners* (RCN, 2012c); *Nursing on the move – specialist nursing for patients requiring repatriation and retrieval* (RCN, 2013b); and *An integrated career and competency framework for ophthalmic nursing* (RCN, 2005a).

Other colleges have also undertaken similar work, such as RCGP’s work on *General Practice Nurse Competences* (RCGP, 2012). The RCN is currently working with HEE and the College of Emergency Medicine in order to agree a multi, as opposed to mono-professional, competency framework in emergency care.

The RCN has also used workload modelling to understand and describe competencies in clinical nurse specialist roles. In 2011, TREND-UK developed a third edition of its *Integrated Career and Competency Framework for Diabetes Nursing* (TREND-UK, 2011). This document provided the framework to support rheumatology nurse specialists in determining their value through the use of a software-based workload modelling tool, which gave beneficial insight into the complex clinical nurse specialist role. The findings of this project are described in *Clinical Nurse Specialists: adding value to care* (RCN, 2010a).
The RCN and our stakeholders have attempted address the challenges of the absence of a national education and development framework by producing work on levels of practice and advanced and speciality practice. However, in the absence of integrated career frameworks, the impact of this work will always be limited and correlate to the good will, or buy in, of regional and local educators and providers.

For example, a recent RCN audit exploring specialist and advanced roles in inflammatory bowel disease found widespread variation in formal levels of qualification and a lack of formal support structures for the role (RCN, 2012f). In a further forum member survey this year, the most commonly cited barriers to appropriate CPD were lack of funding (74%) and lack of available study time (62%). Only when these issues are solved can there be a shared expectation by all that a specific nurse, in a specific role needs a specific set of CPD activities.

An example of this would be emergency nurses operating advanced practice level. It would be hoped that these nurses would have CPD in advanced life support, major incident management, imaging interpretation and so on. However, we know that currently many such nurses do not receive the CPD they need because of regional, inter-professional and public misconceptions about what nurses do and the training they need to do it. This core issue is faced by all nurses and midwives in all setting and specialities in the currently unregulated post-graduate practice environment.

It may be useful to look to international approaches to CPD and career progression. A number of Australia’s states have made efforts at incentivising CPD by more closely linking continuing education to career progression. In Queensland for example, employer appraisals have been used to identify aspiring nurses who might be interested in shadowing and / or undertaking formal training to become part of the senior nursing team. This has helped to create clearer career pathways for more junior practitioners, and have a potential impact on staff retention and development (Ross et al, 2013).

Portugal’s system of continuing education has shown that a strong employer connection between CPD and career progression serves a key incentive for CPD, with Portuguese nurses on average accumulating more study hours than their UK equivalents in spite of the fact that Portugal does not have a mandatory CPD / revalidation system. Annual employer appraisals include a focus on future learning needs and promotion to higher grades is also dependent on a nurse acquiring sufficient CPD.

Systems where CPD is either disconnected from clear routes of career progression or restricted to more senior (non-student) nursing grades, such as is in the People’s Republic of China and the Republic of South Africa, may discourage engagement with continued learning.

The RCN will consider how the work on clinical academic careers can inform and support future faculty development (see the discussion on clinical academic careers under theme 7). There is recognised concern about the lack of sufficient numbers of qualified nursing staff who follow an integrated academic career pathway in higher education to educate the future workforce (Willis Commission, 2012). There is work to consider alternative models to showcase this career pathway both in the UK and internationally, such as a return to a clinical teacher type role. There is also a dearth of evidence and a lack of consensus on what the future nurse educator could or should look like, and this gap in understanding needs to be addressed.

All of the RCN work described above has been undertaken to fix a fundamental problem: the absence of regulation of post graduate nursing education. The UKCC created four national boards whose main functions were quality assurance of education and training programmes
for nurses and midwives, and to maintain the training records of students on these programmes. However, whilst the NMC does have a quality assurance function in relation to education, this is focused on pre-registration programmes and a historic range of post registration recorded qualifications. This post National Board era (since 2002) has seen no national requirements for competencies related to titles, or content related to specific educational courses and no centrally held register for those who have successfully completed qualifications.

The result is mass confusion in relation to the expectation of skill sets and the educational and CDP needs of specific nurses; such as, for example, coronary care nurses, district nurses, school nurses and so on. It also hampers workforce development and responsive commissioning because there is no reliable intelligence about the skills set of the current workforce.

The RCN will continue to build on the work that has already been undertaken by our members, in conjunction with other partners, to develop competency frameworks to support career development within identified areas of clinical practice. This work will also need to address, and be applicable for, the range of settings in which nurses and HCAs work and map to an educational outcomes framework. There will also need to be clarity around terminology used within the framework as there is currently different understandings about the meaning of ‘levels’ achieved; specifically, Skills for Health, QAA and AFC bandings.

The RCN will undertake a review of career and education frameworks offered by other Royal Colleges to draw on good practice and ensure that future nursing frameworks enable interprofessional development and working. For example, the College of Social work has developed a professional capabilities framework, with nine interdependent capabilities identified. There is a synergy between the three development pathways in this framework (educator, practitioner and manager) and the pillars of nursing identified in the first Willis Commission report (practice, management, education and research). We believe the pillars of nursing practice (extended to include ‘policy’ and using ‘leadership’ rather than ‘management’) could offer a helpful structure for exploring career development.

In a fast paced and changing health care context, there are challenges in expanding the scope of practice within and across the professions. The modernisation agenda has contributed to the blurring of boundaries around professional practice; a workforce can diversify, specialise or substitute within its roles to meet changing needs (Nancarrow and Borthwick, 2005). Education and training for the nursing workforce must be clear in what it is seeking to achieve in developing the workforce, as changes in a profession’s scope of practice has implications for their regulatory model, indemnity issues and public perceptions of the role.

**Theme 7: Supporting and enabling research, innovation and evidence based practice**

**Summary**

It is essential to create a culture of research, innovation and knowledge translation in order to future-proof the nursing workforce. This ambition is central to the RCN’s *Knowledge and Innovation Action Plan 2014 - 2018*, which underpins our work in supporting nurses to use knowledge in policy and practice, and to feel confident in using research and innovation to enhance care.
Clinical-academic nurses and advanced practice nurses play important roles in promoting uptake of evidence through role modelling, teaching, clinical problem solving and facilitating change. In acting as experts, champions and boundary spanners, these roles are important in the diffusion of innovation and the transfer of knowledge. However, there is also a need for further research into how the frameworks for advanced practice and clinical academic careers align with current models supporting the development of the nursing education workforce.

**RCN Knowledge and Innovation Action Plan**

The RCN has over 50 years of experience supporting and enabling research and innovation. In 2013, we developed a new *Knowledge and Innovation Action Plan* (RCN, 2014b) that underpins all knowledge and innovation activities across the RCN. It includes a vision statement that aligns clearly with the current theme: ‘Developing nurses and nursing through knowledge and innovation to transform care’.

The *Knowledge and Innovation Action Plan* sets out the ways in which the RCN will use, build, assure and share knowledge over the next five years, and is presented across those four key areas:

**Use knowledge:** We promote the use of knowledge to influence policy and to inform decisions and nursing actions. We provide tools and help people develop the skills and confidence to ask questions, make evidence-informed decisions, innovate and adapt in response to changing needs.

**Build knowledge:** We contribute to and maintain a knowledge base for nursing, ensuring that the nursing contribution to national and international multi-professional health research agendas is explicit. This contribution includes identifying and helping to fill gaps in standards, guidance and knowledge resources of relevance to nursing, and continuing to build the authoritative collection on nursing in the UK.

**Assure knowledge:** Our outputs are evidence informed, impartial and clear about the source, quality and strength of evidence presented. Our cataloguing of the RCN collection assures its intellectual integrity.

**Share knowledge:** We connect members to the knowledge they need so they can use it to improve quality of care. Format and content is relevant for people with different levels of expertise, roles, settings and influence. The content and expertise of the RCN library and archive, and the staff supporting its use, inspire the nursing community and the public to gain an insight into the past, present and future of nursing.

The *Knowledge and Innovation Action Plan* is appended in its entirety to this document for information.

**Information literacy**

Information literacy is a fundamental skill required by everyone in an information age and a prerequisite to generating knowledge through research and evaluating innovation to assure safe and effective care.

One of the key drivers and enablers of information access is the internet and social media. Internet usage has grown exponentially, with only 13% of households having access to the internet in 1999 whilst in 2013 the figure was 83% (HEE, 2014). Whilst historically the
internet is still a fledgling technology, it has already made significant impact on the way people access information, innovate and interact with each other. As internet usage continues to grow, and websites like NHS Choices become ever more useful, information literacy and people’s knowledge of their health will increase and patients may be more prepared to challenge healthcare staff. As a result, nurses will require knowledge and training to ensure that patients are armed with the best available evidence. Training and development will be required not only to keep up with a rapidly expanding evidence base, but also with an increase in technology such as telehealth, mobile diagnostics and a paperless NHS.

Access to information needs to be coupled with the knowledge skills and competencies to use information to help ensure that care provided is safe and effective, based on the best available evidence. To that end, the RCN has developed information literacy competences on Finding, Managing and Using Information (RCN, 2011).

These competences detail the skills needed to recognise when and what information is needed, to identify, locate, evaluate, interpret and apply information. They are intended to support the individual and the nursing team’s thinking about the information required to inform activities of varying complexity.

The RCN has also developed a learning resource to accompany the information literacy competences, How trustworthy is your information? (RCN, 2014h) This open access resource has been developed primarily for students, nurses, midwives and health care support workers who may be routinely researching topics in support of their day-to-day work, or who are currently in education. It aims to encourage learners to think about why trustworthy information is essential to their practice, and what they can do to get the right information at the right time. It also aims to show learners how they can use information legally, inclusively and ethically.

The RCN also provides learning workshops available to all RCN representatives that will develop their skills in searching for and evaluating information. A 90 minute workshop includes discussion of techniques for searching key information resources, identifying methods for evaluating a policy and applying them to a specific document.

Clinical-academic pathways

There are a number of powerful case studies of the benefit and return on investment of nurse leaders who successfully combine clinical and academic work. For example, at UCL Hospitals (UCL Hospitals, 2014) the designated lead nurse for children and young people with diabetes provides professional advice, leadership and direction to the clinical nurse specialist diabetes team and paediatric diabetes dietician. This leadership remit also extends to a wider audience, with an expectation to improve and influence national policy making for children with diabetes. The nurse consultant also contributes to a number of national working groups. The remaining portion of the role is spent developing educational and research programmes to support the post and is also an honorary senior lecturer at City University. This role was established to decrease waiting times and optimise the pathway for new referrals into the service, specifically for insulin pump therapy. The role has contributed to a reduction in waiting times to less than two weeks for new appointments and shortened the waiting time for children and young people to initiate insulin pump therapy.

Similarly, the children’s diabetes nurse specialist who holds a joint appointment with the Royal Manchester Children’s Hospital and the University of Manchester as a clinical academic researcher enables clinical practice to influence research and research to influence practice (RCN, 2014d). This research-practice cycle and consequently research-
into-practice link that is afforded academic careers is the most compelling reason for greater investment and focus into this area.

However building a critical mass of nurses with the capability to undertake research and innovate in practice requires sustained investment, within a culture that recognises the value of research and innovation skills in practice and ensures that they are utilised to maximum effect. This can be achieved by bringing together the best of academic research and the best of clinical practice through a nationally recognised clinical-academic career option within an overarching nursing career pathway.

The RCN is currently working to address a gap in the preparation of nurses at pre and post registration level in understanding the principles of economic assessment and applying them in practice. Nurses have come onto the programme having recently completed a higher degree (for example) and describe the programme as ‘the bit that was missing from their Masters’. Building capability in economic assessment should be incorporated into all curricula that aim to support and enable research, innovation and evidence based practice.

We have good examples of where capability and culture building is successful. In the Collaboration for Leadership in Applied Health Research and Care for South Yorkshire (CLAHRC SY), RCN Fellow Professor Kate Gerrish leads the Translating Knowledge into Action theme and is implementation lead for the CLAHRC SY as a whole. She holds a joint post as Professor of Nursing Research with the University of Sheffield and Sheffield Teaching Hospitals NHS Foundation Trust where she contributes to the strategic leadership of nursing research and implementation of evidence-based practice. Prof Gerrish has a longstanding research interest in the area of knowledge translation with a focus on the implementation and evaluation of strategies to promote evidence-based practice. She has published widely in her field and has presented papers at national and international conferences, as well as serving on a number of national research committees. The work of the Collaboration has enabled nurses to be directly involved in the research process, many of whom report their research at the RCN’s annual international nursing research conference. Examples of this work include projects on mattress triage (Wragg 2013), service redesign (Hunter, 2013), prevention of pressure ulcers (Clegg, 2013) and hepatitis C (Poll, 2013).

Nurses in Southampton have made a significant contribution to our collective thinking on the development and implementation of clinical academic careers. For example colleagues from the University of Southampton led the development of the Southampton Clinical Academic Career Pathway and the Clinical Academic Careers Capability Framework which both underpin the AUKUH collaborative national endeavours activity. In Southampton significant advances have been made in building research capability within the context of a clearly defined career pathway.

Similarly in Scotland, Lothian have led the way in developing clinical academics within the context of a career pathway (MacArthur and McCulloch, 2012). The main features of Scheme are that there is a formal service level agreement in place between the 5 partners (NHS Lothian, three Universities and NES); it is embedded in the NHS with a service manager as the lead applicant; there are three demonstration sites; funding for 6 0.5 WTE clinical academic staff; five years of funding (@£150K per annum); and there is funded PhD training. Criteria for funding sites included: service/academic collaborations; a research track record; an original and coherent programme of research; importance & potential impact to NHS Lothian; university priority area; clarity, rigour and feasibility; and sustainability.

It should be noted that career pathways specify ‘NIHR or PhD award scheme’ because NIHR and CSO will only recognise a PhD as a pre-requisite doctoral qualification to a post-doctoral research award and hence a career or leadership role in research. This immediately
excludes anyone who has completed a professional doctorate. Exclusion of professional doctorates is problematic and this needs addressing. There are prejudicial views within the academic community about professional doctorates, which have come under criticism for being less rigorous than a PhD and can be viewed as a lesser award (Lee et al, 2009). There is much confusion within the academic community about the professional doctorate, with its profusion of titles and variety of pathways to the award. Justifications for the differences in approach have given rise to debates about the type of knowledge generated (Rolfe and Davies, 2009), the type of student who is attracted to the programme (Bourner et al, 2001) and the nature of the researcher (Galvin and Carr, 2003). There is an assumption that a professional doctorate does not build the requisite capability, despite these having to meet the level eight descriptors set by the Quality Assurance Agency. This assumption should be challenged and the capability frameworks may be the means of doing that.

The RCN has been and continues to work with a wide range of strategic partners to promote clinical-academic careers. Currently this is being progressed through the Association of UK University Hospitals (AUKUH). The report of the AUKUH National Clinical Academic Careers Development Group for Nurses and Midwives (AUKUH, 2013) made recommendations to progress clinical-academic careers in nursing. AUKUH National Clinical Academic Careers Development Group for Nurses, Midwives and Allied Health Professionals (NMAHPs) have a campaign strategy to secure cross-stakeholder support for 1% of NMAHP posts to be clinical-academic (i.e. requiring research training / actively engaged in research) across the UK by 2020, 3% by 2030, 4% by 2040, and 5% by 2050.

The NIHR / HEE Clinical Academic Training Programme for Nurses, Midwives and Allied Health Professionals has increased capacity in this area. There are also Research Institutes undertaking research relevant to nursing that specifically focuses on the science of implementing research evidence into practice. For example RCN Research Institute, University of Warwick has a programme of research looking at implementation of evidence into practice, and University of Bangor has a Professor of Implementation in Health. These valuable resources provide rigorous knowledge on how to get research embedded into practice. Finally, the Health Foundation have funded Improvement Science fellowships, which increase capacity of those who are expert in research implementation.

Clinical-academic and advanced practice nurses act as knowledge brokers in promoting evidence-based practice among clinical nurses (Gerrish et al, 2011). Knowledge management involves generating different types of evidence, accumulating evidence to act as a repository for clinical nurses, synthesising different forms of evidence, translating evidence by evaluating interpreting and distilling it for different audiences and disseminating it by formal and informal means. Clinical-academic and advance practice nurses promote the uptake of evidence by developing the knowledge and skills of the clinical nurses through role modelling, teaching, clinical problem solving and facilitating change.

Successful development, expansion and implementation of clinical academic careers will require both nationally coordinated investment as well as local organisational investment. It is the latter which is particularly important since roles and opportunities will need to be made for clinical-academic nurses to fill. Within current education commissioning arrangements, some nurses are not supported to undertake Masters, PhDs or post-doctoral programmes. Nurses who have completed a PhD may be unable to bring this to their clinical practice, with resulting missed opportunities for innovation and research based practice. Commissioning and funding levers will be required to correct these supply-side inefficiencies.

Whilst acknowledging that clinical academic careers offer an important pathway for supporting evidence into practice, the focus for this route is around research and clinical practice. Whilst education and development is a recognised component of this role, it is less clear how this aligns with the current model for the nursing education workforce. The
synergies between a clinical academic researcher and a university based nurse academic are not clear and the focus of the two roles are different. The NMC teacher standard (within the standards for learning and assessment in practice) do not reflect the requirements for a clinical academic career. We believe that further work is required to identify the model that will ensure that tomorrow’s nursing educators are supported and developed to meet the future needs of the healthcare workforce.

**Theme 8: Funding and commissioning levers that can support education and training for the future**

**Summary**

Investment is needed to incentivise organisations to encourage their staff to participate in and lead research projects, including funding back-fill for staff to accommodate commitments to research activities. Funding and commissioning should be linked to scholarships to encourage nurses to undertake further learning and development.

**Incentivising research and innovation**

Organisations must be incentivised to encourage their staff to participate in and lead research projects. This can be done by ensuring funding is available for replacing staff deployed to research-related activities. Funding and commissioning should also be linked to scholarships to encourage nurses to undertake further learning and development.

By strengthening the link between career progression and continuing professional development, staff may be more motivated to invest in training and development outside their normal practice if the link between such investment and remuneration is made explicit.

Whilst such upfront investment would require significant commitment from stakeholders, the potential return on investment is great. For example, in Scotland a heart failure clinical nurse specialist demonstrated that her nurse liaison service avoids hospital admissions and reduces the burden on primary care. The calculated costs avoided amounted to £454,928 per annum realising an average return on investment of £489 per patient. With improved referral rates this could be increased to between £671 and £779. The clinical nurse specialist is currently working with her Director of Nursing to extend the reach of her service and is also advising MSPs and service planners across Scotland (RCN, 2013d).

Other examples include a clinical nurse specialist in Wales who is providing psychotherapeutic interventions to local authority colleagues through a partnership agreement between the health board and local authority. A return on investment of between £1.89 and £2.67 for every £1 spent was demonstrated and the clinical nurse specialist is currently advising the Welsh Assembly Government on the value of partnership working to improve mental health and productivity within the public sector (Royal College of Psychiatrists, 2012).

Additionally, a clinical nurse specialist in Northern Ireland who provides an integrated children’s continence service with an open referral system realised a cost saving for cases of bed wetting of £370 per case compared to traditional consultant paediatrician led services. Similar savings were realised for constipation and soiling. Even without monetising the benefits to families when incontinence is effectively managed or cured or when a service is
provided locally, the clinical nurse specialist service demonstrated significant economic efficiencies (RCN, 2014c).
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Appendix 1: Comparative international terms for health care assistants

In submitting evidence for each of the eight themes, the RCN has drawn on both UK and international evidence. For the latter, it is important to note that the use of the term, ‘Healthcare Assistant’ is not universally defined or recognised. Consequently, there are significant disparities in the nature and duties of the HCA role, with Australia and the United States (US) providing just two examples of multiple HCA career paths under various professional titles, some of which are regulated and others which are not. It is important then that the reader understands that international comparisons will not immediately cross-over to the UK context and that in this paper the use of the term ‘HCA’ invariably refers to a diverse set of roles. A selection of some of the comparative terms used in other countries and the extent to which HCAs are regulated within these jurisdictions is provided below.

Australia – ‘Assistants in Nursing’ and ‘Enrolled Nurse’
Assistants in Nursing: The more junior of Australia’s two HCA work streams. There are no formal educational requirements and applicants can undertake traineeships at various hospitals and medical colleges. Their primary role is to support registered nurses (RNs) and doctors and to perform basic care functions for patients, such as monitoring vital signs.

Enrolled Nurses (ENs): Similar to the US ‘Licensed Practical Nurse’. ENs must complete a Diploma of Nursing and will usually spend 24 months training, consisting of 36 weeks theoretical learning at colleges or private institutions, followed by practical experience in hospital wards for the remainder of that time. The majority of ENs eventually move on to attend university and become RNs, although a substantial number remain at the EN level in public/private hospitals and nursing homes.

Brazil – ‘Nursing Auxiliary’
Brazil requires that auxiliaries undertake one year pre-registration training as set out in Law 7.498/86. There are no post-registration regulations or educational requirements. Auxiliaries provide the majority of what would be considered nursing care.

Finland – ‘Practical Nurse’
HCAs are required to undertake three years of training and, as with Austria, Bulgaria, the Czech Republic, Denmark, Italy and Slovenia, the work tasks and duties of healthcare assistants and their education are regulated. This regulation goes along with the requirement to obtain a licence to practise after finishing the mandatory HCA education and training.

Germany – ‘Assistant Nurse’
The government of each of the 16 federal states is responsible for the regulation of the HCA profession and its education. Only Lower Saxony has a unified curriculum for HCAs.

Japan – ‘Assistant Nurse’
Japan operates a mandatory permitting (licensing) system. Licenses are issued only after completion of two years of approved training.

Sweden – ‘Nursing Assistant’
Completely unregulated.

United States – ‘Nursing Assistant’ and ‘Licensed Practice Nurse’
Nursing Assistant: No formal training is required to practise, although there is a voluntary federal licensing system (known as Certificate 111). To obtain this, individuals must undertake 75 hours of approved training, followed by a competency examination. Gaining a Certificate 111 is important if a Nursing Assistant wants to move up to become a Licensed Practice Nurse (see next entry).
Licensed Practice Nurse: LPNs (also known as licensed vocational nurses in California and Texas) usually have 18 months to two years of training in anatomy and physiology, medications, and practical patient care. They must pass state or national boards and renew their license periodically. LPNs perform simple as well as complex medical procedures but usually operate under the supervision of an RN or doctor. They can administer most medications (usually with the exception of IV push medications), perform measurements (for example, blood pressure, temperature), keep records, perform CPR, maintain sterile and isolation conditions, and administer basic care.

The following documents have been appended to the RCN submission:

- Appendix 2: RCN Knowledge and Innovation Plan
- Appendix 3: RCN Principles of Nursing Practice
- Appendix 4: Examples of RCN work on competences
  - The role of the link nurse in infection prevention and control
  - Advanced nurse practitioners