Royal College of Nursing response to the All-Party Parliamentary Group on Global Health's consultation on the future development of nursing globally

The Royal College of Nursing (RCN) is pleased that the views and priorities included in this written submission to the All-Party Parliamentary Group (APPG) on Global Health has been endorsed by the International Council of Nurses (ICN). The ICN is a federation of more than 130 national nurses associations[1].

The RCN and ICN are committed to supporting the APPG in this valuable work, and we welcome any future opportunities to engage and contribute.

Introduction

The RCN welcomes this review by the APPG on Global Health. Nursing has a critical role to play in helping national health systems deliver universal health coverage (UHC) and the Sustainable Development Goals (SDGs).

To realise this however registered nurses need to be recognised in the same vein as the Prime Minister's 2010 Commission on the Future of Nursing and Midwifery in England.[2] This means that registered nurses should be:

- skilled and respected frontline practitioners providing high quality care across a range of settings;

- vital and valued partners in the multidisciplinary team, coordinating resources and skill sets to ensure high quality care; and

- confident, effective leaders and champions of care quality with a powerful voice at all levels of the health care system.

The RCN recognises that this consultation is unique, in part because the RCN (as a UK-based organisation) is presenting advice to the UK Parliamentarians on how it can support the development of nursing globally. As this is a huge topic with many different facets, we have focussed our response on headline issues where the RCN has the strongest experience, and where the APPG can make a substantial impact.

[1] More information on the ICN can be accessed here: http://www.icn.ch/who-we-are/who-we-are/.

[2] National Archives, 'Front Line Care: Report by the Prime Minister's Commission on the Future of Nursing and Midwifery in England', available at: webarchive.nationalarchives.gov.uk/.../http:/.../front_line_care.pdf (2010)

As a follow-up to this written submission, we will be providing some UK and international case studies which illustrate in more detail the key contribution of nursing in the areas raised in our submission.

Responses to specific questions

For purposes of ease and clarity, we have merged our answers for questions one and two of this consultation. Our recommendations to the UK Government are covered separately in question three.

How does nursing need to develop globally in order to contribute most effectively to improving health globally and delivering Universal Health Coverage?

What are the key issues that need to be addressed globally in order to enable nursing to develop in this way?

1) **Investing in education and development**

On a global scale, nursing provides an absolutely critical offering to the world's women, both as users and providers of healthcare. Besides extending a valuable education (which is itself is a vital global priority), nursing offers women a route for professional, social and economic independence which is positive for socio-political stability, wealth-creation (including increased tax receipts, growth of the workforce etc[3]), as well as national health outcomes.

On nurse education specifically, this is a critically important area. It provides the foundation for knowledgeable, effective and caring practitioners, and also sets the precedent for continued life learning. By prioritising education and continuing professional development (CPD), nursing skills are able to evolve and develop in line with patient and population needs. This is especially important for realising better preventative care and for supporting health systems in shifting towards an older demographic more prone to non-communicable diseases (NCDs).

International research published in 2014 found that every 10 per cent increase in bachelor's degree nurses was associated with a decrease in the likelihood of a patient

[3] Europe's World, 'Empowering Africa's women is the key to economic wealth', available at: http://europesworld.org/2014/02/24/educating-africas-women-is-the-key-to-economic-wealth/#.VrnhZxtF2Uk (2015)

dying by seven per cent.[4, 5] As such, the RCN would urge that the World Health Organisation's (WHO's) guidance which states that nursing education be set at degree level with a minimum of 12 years of general education beforehand, be emulated across the global nursing profession.

However, a degree education retains its value only when nurses have access to, and support for continued learning. This can take many forms, but basically results in nurses observing and innovating new and better ways of delivering care, expanding their base of clinical knowledge, and building ever greater trust with patients and communities.

Nurses often take on the role of educating the public, families and lay workers about pressing health risks. This can help change behaviours - preventing long term deterioration which is far more expensive and challenging to reverse. In the UK for example, nurses working in the public health arena play a vital role in supporting vulnerable groups and empowering community assets to take greater control over their future health outcomes – including those recovering from post-industrial economic decline.

However, investment in education and CPD also needs to be partnered with a holistic workforce programme which incentivises nurses to remain in the profession. The world is currently facing a chronic shortage of nurses and so nurturing a self-sufficient supply is important, especially for less robust health systems in advancing UHC.

2) Valuing the workforce

In the UK, investment in nursing has continued to face significant downward pressure since the 2008/09 global recession and this has had severe consequences for enabling the health service to deal with rising, and increasingly complex patient demand. The WHO and the Organisation for Economic Co-operation & Development (OECD) have said that well-planned investment in the health workforce should be considered pro-growth and pro-job creation,[6] and this is supported by the experience

[4] King's College London, 'Degree educated nurses can reduce hospital deaths', available at: http://www.kcl.ac.uk/nursing/newsevents/news/2014/Degree-educated-nurses-can-reduce-hospital-deaths.aspx (2014)

[5] The Lancet, 'Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study', available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62631-8/abstract (2014)

[6] OECD, 'Health and the Economy: A Vital Relationship', available at: http://www.oecdobserver.org/news/archivestory.php/aid/1241/Health_and_the_economy:_A_vital_relationship_.html (2004)

of the UK and other countries[7] where reduced investment in workforce numbers (including retention levers such as pay) has led to increased overall costs for the health system.[8]

But this challenge extends beyond just recruiting more nurses. Since the recession, the UK Government has focused on reducing the numbers of senior, experienced nursing leaders in order to make savings.[9] A shift in mind-set is needed to acknowledge that nursing often provides the solution for health challenges rather than a drain on resource from staff salaries. This view is supported by evidence collected by the OECD.[10]

Learning from this experience, it is critical that the full scope of practice of nursing be recognised and supported – including the frontline, leaders and advanced practitioners/specialists. Advanced practice roles for example, such as nurse prescribers, continue to enable the UK's NHS to operate more effectively. This positive benefit has also been observed in Botswana where in 2009 a cross-sectional study showed that nurse prescribers looking after HIV-infected children delivered outcomes as good as (and in some cases even better) than those of doctors.

The growth of specialist and advanced practice needs to be welcomed and supported not only in acute but also community settings. These roles improve patient care, but they also provide clear career development opportunities which help improve retention and boost morale. However, maximising advanced practice also requires the development of appropriate regulatory and training mechanisms so that a level of assurance can be gained that those practising in an advanced capability are able to meet public and patient expectations around their capability.

Delivering this is an ongoing challenge but one area where more could be done (including for the UK) is on the collection, analysis and informed use of data and statistical information. The RCN would echo the view of the WHO that stronger data

[7] RCN, 'Ontario's (Canada) deficit crisis and health reforms: Lessons for the UK', available at: http://www.rcn.org.uk/__data/assets/pdf_file/0007/482353/23.12_Ontario_1990s_health_care_reforms_briefing_FINAL.pdf (2012)

[8] RCN, 'Frontline First: Runaway Agency Spend', available at: http://frontlinefirst.rcn.org.uk/sites/frontlinefirst/index.php/pages/reports/ (2015)

[9] RCN, 'More than just a number', available at: http://frontlinefirst.rcn.org.uk/blog/entry/more-than-just-a-number-reckless-policy-draining-nhs-of-experience/ (2014)

[10] OECD, 'Nurses in advanced roles: A description and evaluation of experiences in 12 developed countries', available at: http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=delsa/hea/wd/hwp(2010)5&doclanguage=en (2010)

collection systems are required in order to advance a sustainable workforce agenda.[11]

3) Leadership at all levels

Good nurse leadership is vital for maximising the capability of the global health workforce. The experience of the UK shows that effective leaders pioneer and integrate new, innovative practices and this in turn is picked up and followed by those who observe them.

A large number of UK (including government) reports[12], as well as separate RCN research[13] has recognised the vital role of supernumerary (or equivalent) ward and executive leaders in ensuring that good patient care is delivered and resources are managed effectively. This also extends to countries beyond the UK, with RCN research showing that patient care is improved when leaders are empowered to develop new solutions to team management and resource utilisation.[14]

In practice, there is ample international evidence that allowing nurse leaders to lead and shape the delivery of health services is good for innovation, patient outcomes, recruitment and retention. In the Netherlands for example, the Buurtzorg district care model has grown rapidly since its founding by a nurse in 2006. By empowering frontline nurses to deliver care autonomously, Buurtzorg has managed to significantly reduce costs of care and deliver better patient care and satisfaction.

In addition to the experience of Buurtzorg, an OECD evaluation of advanced nursing practice across twelve developed countries, found that advanced practitioners not only improved access to services and reduced waiting times, but that they also delivered the same quality of care as doctors for a range of patients, including those with minor illnesses and those requiring routine follow-up.[15]

What this reinforces is a need to build and strengthen leadership at all levels for the long term - including within heath service providers and ministries and enhancing the role of chief nursing and midwifery officers. Maintaining and enhancing this positive

[11] WHO, 'Global Strategy on Human Resources for Health: Workforce 2030', available at: http://www.who.int/hrh/resources/online_consult-globstrat_hrh/en/

[12] Francis Inquiry (2013), Keogh Report (2013), Willis Commission (2012) and Shape of Caring Review (2015), among others

[13] RCN, 'Leadership - RCN support', available at: https://www2.rcn.org.uk/development/practice/clinical_governance/leadership/rcn_publications

[14] RCN, 'Frontline Ward Managers – An International Perspective' (2016)

[15] OECD, Nurses in advanced roles: A description and evaluation of experiences in 12 developed countries', available at: www.oecd-ilibrary.org/.../nurses-in-advanced-roles_5kmbrcfms5g7-en (2010)

influence remains a challenge in the UK countries as well as more resource poor countries.

This work also needs to factor in continued gender imbalance, for while women play a vital role in delivering health services and supporting patients and families, this is not reflected in senior leadership structures. Gender has a significant influence on decision-making - within households and at professional and policy level. To build strong health systems nurses need to be respected and valued as a vital part of multi-disciplinary teams.

One tool for overcoming this challenge is greater support for, and partnership between national nursing associations/trade unions. These bodies can focus the voices of existing and aspiring nurse leaders together to help develop robust clinical guidance, support the development of evidence-based health policies, hold governments to account in a constructive manner, and advocate for better terms and conditions for health workers.

The RCN is putting this principle into practice through its capacity-building partnership with the Zambian nursing association and trade union - the Zambia Union of Nurses Organisation (ZUNO). This is supporting ZUNO to have a greater influence on nursing policy and practice. As part of the partnership we are working with ZUNO to establish nurse leadership within multi-disciplinary teams to improve patient safety and demonstrate the value of a strong national professional voice.

Nursing associations also benefit from membership opportunities to various international networks which share best practice and give nursing a global voice. These include the European Federation of Nurses' Associations (EFN), the International Council of Nurses (ICN) and the Commonwealth Nurses and Midwives Federation (CNMF).

3. What are the key issues that need to be addressed globally in order to enable nursing to develop in this way?

Much of what has been said in this submission is already recognised and well evidenced what is now needed is action by governments including finance ministries, international agencies and donors, policy makers, health leaders and nurses themselves including:

- UK government support for the WHO's Strategy for Human Resources for Health – including self-sufficiency milestones for all countries including the UK, and a much stronger cross sectoral approach to human resourses for health strategies – across ministries (health, finance, home office, education etc..) and

with professional associations and trade unions.

- Department for International Development's (DfID) forthcoming health system strengthening strategy needs to commit to investing an agreed percentage of overseas development aid into the development of the nursing workforce which is vital to sustainable health systems.

- DfID has a strong track record in prioritising the needs of women and girls integrating gender into its development work. We hope that they will encourage other countries to take similar action.

- A renewed cross-governmental strategy on global health (building on 'Health is Global') with a clear action plan is needed , reflecting the new Sustainable Development Goals and how the UK contributes to achieving these at home and abroad, including addressing the three key themes in this RCN submission.

- Recognition within country programmes run by the Department for International Development (DFID) of the role which national nurses associations can play in supporting leadership, professional development and advocacy and continuing support from DfID programmes for institutional capacity building partnerships.

- The NHS and other health and training institutions to recognise the value of coordinated volunteering and long-term partnerships/twinnings between health organisations, in the UK and in developing countries and continue to work to overcome barriers to UK based nurses and other health team members being able to contribute. This should also include better opportunities for participation in and accreditation of overseas electives which allow student nurses to exchange practice and knowledge

- Nursing still has very limited representation in key national and international health fora – particularly the World Health Organisation, but also within national ministries. The UK government needs to champion and model greater multi-disciplinary working and nurse representation in such fora.

- Following the APPG's 2015 report, 'The UK's Contribution to Health Globally: Benefiting the Country and the World'[16], we recommend that the APPG take a more in-depth look at initiatives and projects with a strong nursing focus to identify areas of impact and best practice.

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[16] APPG, 'The UK's Contribution to Health Globally: Benefiting the Country and the World', available at: http://www.appg-globalhealth.org.uk/reports/4556656050 (2015)

Supplementary evidence and case studies for the All Party-Parliamentary Group (APPG) on Global Health

From Royal College of Nursing

Introduction

In our written submission to the APPG (February 2016), we committed to providing additional evidence in the form of case studies to support our views.

This document collects case studies from a number of countries (including the UK), which illustrate the value of investing in the following key areas of global nursing:

- Education
- Advanced Practice
- Public Health
- Leadership and capacity-building

We hope that these provide a practical illustration of how nursing is a critically positive factor in addressing the rapidly changing health needs of populations around the world.

It is however an undeniable fact that in order to achieve the outcomes described below that the right investments need to be put in place, and nurse empowerment needs to be prioritised.

Education

Case study one: Study covering nine European countries

Situation: Austerity measures and health-system redesign to minimise hospital expenditures risk adversely affecting patient outcomes. The RN4CAST study was designed to inform decision making about nursing, one of the largest components of hospital operating expenses. We aimed to assess whether differences in patient to nurse ratios and nurses' educational qualifications in nine of the 12 RN4CAST countries with similar patient discharge data were associated with variation in hospital mortality after common surgical procedures.

Action: For this observational study, the RN4CAST obtained discharge data for 422 730 patients aged 50 years or older who underwent common surgeries in 300

hospitals in nine European countries. Administrative data were coded with a standard protocol (variants of the ninth or tenth versions of the International Classification of Diseases) to estimate 30 day in-hospital mortality by use of risk adjustment measures including age, sex, admission type, 43 dummy variables suggesting surgery type, and 17 dummy variables suggesting comorbidities present at admission. Surveys of 26 516 nurses practising in study hospitals were used to measure nurse staffing and nurse education. We used generalised estimating equations to assess the effects of nursing factors on the likelihood of surgical patients dying within 30 days of admission, before and after adjusting for other hospital and patient characteristics.

Outcome: An increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7 per cent (odds ratio 1·068, 95 per cent CI 1·031–1·106), and every 10 per cent increase in bachelor's degree nurses was associated with a decrease in this likelihood by 7 per cent (0·929, 0·886–0·973). These associations imply that patients in hospitals in which 60 per cent of nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30 per cent lower mortality than patients in hospitals in which only 30 per cent of nurses had bachelor's degrees and nurses cared for an average of eight patients.

Nurse staffing cuts to save money might adversely affect patient outcomes. An increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths.

Source: The Lancet, 'Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study', available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62631-8/supplemental (2014)

Case study two: The Future of Nursing: Leading Change, Advancing Health, United States

Situation: The Institute of Medicine (IOM) is a division of the National Academies of Sciences, Engineering, and Medicine in the US. The Academies are private, non-profit institutions that provide independent, objective analysis and advice to the US Government and conduct other activities to solve complex problems and inform public policy decisions related to science, technology, and medicine.

Action: In 2010, the IOM produced a ground-breaking report on the future of nurse education in the US, called 'The Future of Nursing: Leading Change, Advancing Health'. This nonpartisan report which brought together the work of 18 experts in nursing, medicine, economics, business, hospital administration, health policy, workforce policy, and health plan administration, outlined a blueprint for transforming

the nursing profession to enhance the quality and value of US health care in ways that meet the future needs of diverse populations.

One of the most viewed online reports in the IOM's history, this landmark report calls on the nation's leaders and stakeholders to act on its recommendations, including changes in public and institutional policies at the federal, state, and local levels. To spur this action, RWJF has partnered with AARP on the Future of Nursing: Campaign for Action. The campaign's vision is for all Americans to have access to high-quality, patient- and family-centred care in a health care system where nurses contribute as essential partners in achieving success.

Outcome: The committee recommended that the proportion of nurses with bachelor degree level qualifications be increased to 80 percent of the workforce by 2020 (it was approximately 36 per cent in 2008). While it anticipates that it will take a few years to build the educational capacity needed to achieve this goal, the committee maintained that it is bold, achievable, and necessary to move the nursing workforce to an expanded set of competencies, especially in the domains of community and public health, leadership, systems improvement and change, research, and health policy.

In addition to increased numbers of degree-educated nurses, the IOM also recommended that schools of nursing build their capacities to prepare more students at the graduate level who can assume roles in advanced practice, leadership, teaching, and research. The report also noted that nurses with doctorates are needed to teach future generations of nurses and to conduct research that becomes the basis for improvements in nursing science and practice. The committee recommends doubling the number of nurses with a doctorate by 2020.

Source: Institute of Medicine (IOM), 'The Future of Nursing: Leading Change, Advancing Health', available at: http://iom.nationalacademies.org/About-IOM.aspx (2010)

Advanced Practice

Case study one: Nurse prescribing delivers parity of outcomes with doctors, Botswana

Situation/Action: A cross-sectional study was conducted in 2009 by the Botswana-Baylor Children's Clinical Centre of Excellence (COE). This compared the performance of nurse prescribers to doctors caring for HIV-infected paediatric patients. Selected by stratified random sampling, 100 physician and 97 nurse prescriber encounters were reviewed.

Outcome: The results showed that nurse prescribers and doctors correctly documented 96 per cent and 94.9 per cent of the time, respectively. There was also evidence that nurses undertook a higher level of social history documentation.

The findings led the COE to reaffirm their support for continued investment in employing nurses to provide quality care and antiretroviral treatment services to HIV-infected children. The COE is also advocating for this approach to be adopted across southern Africa.

The report concluded that task-shifting to nurses continues to show great promise for scaling up and sustaining adult and paediatric antiretroviral treatment, particularly where provider shortages threaten rollout.

Source: US National Library of Medicine, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3674816/ (2014)

Case study two: A review of Advanced Practice Nursing, Hong Kong

Situation: Hong Kong's health system does not have a significant capacity for primary health care, and individuals will usually first be seen for a significant ailment in the emergency department. Once diagnosed with a condition and stabilised to no longer need inpatient treatments, they will then be referred to see a specialty clinic on an outpatient basis.

Due to the lack of such clinics, the Hospital Authority of Hong Kong developed the concept of nurse-led clinics with specialty nurses providing care and management to individuals with that ailment. For example, for an individual with Chronic Obstructive Pulmonary Disease (COPD), an individual would go to a COPD clinic.

Action: Advanced Practice nursing began in Hong Kong during the 1990s. These individuals often carry their own patient load, but may also see patients on other wards that have specialty needs. The roles of these specialists within the hospital systems vary according to hospital and specialty. This role has developed significantly further with Nurse Specialists leading out-patient clinics.

Outcome: Since inception, these nurse-led clinics, have been continuing to expand and have demonstrated good improvement to healthcare. The nurses in these clinics can manage up to 90 per cent of patients for outpatient disease-specific care. Most often the nurses in these clinics will practice either independent or supervised adjustments of medications and initiating diagnostics or treatments according to protocols.

Source: International Advanced Practice Nursing, 'Advanced Practice Nursing in Hong Kong', available at: http://internationalapn.org/2013/10/28/hong-kong/ (2013)

Case study three: Positive outcomes emerge from advanced nurse practice, Thailand

Situation: Advanced practice nursing was first approved in 2003 by the Thailand Nursing and Midwifery Council (TNMC). The first study to analyse the impact of this role was undertaken in 2010.

Action/Outcome: Findings from the first phase revealed APN performance was high within the roles of direct clinical care, educator, consultant, administrator and researcher, while performance within the role of ethicist/legalist was moderate.

Results from the second phase revealed APN role development was comprised of three stages: advanced beginner, competent practitioner and expert. The major facilitating factors of APN role development were found to be: a) organisational (healthcare system and organisational policies); b) human (quality nurse administrators and well-functioning multidisciplinary teams) and c) resources (financial
assistance).

Outcome: Based on the findings, the report recommended that APNs be supported to work across the full remit of their skills-set going forward and that standards and expectations be made more consistent across the institutional, regional and national level.

Source: Role Development of Advanced Practice Nurses in Thailand, available at: https://www.tci-thaijo.org/index.php/PRIJNR/article/download/6302/5501 (2010)

Public Health

Case study one: Andra Pradesh, India

Situation: An ongoing programme for the fifth largest state in India, with a total population of around 80 million (73 per cent of whom live in rural areas). Andhra Pradesh is also among the six Indian states with the highest prevalence of HIV/AIDS:

estimated among adults at 0.97 per cent, or 21 per cent of all people living with HIV/AIDS in India.

Action: In India the decentralisation of HIV/AIDS services to regional level has been critical for people living in rural and remote areas, especially for access to counselling and testing services, which provide a gateway for the entire range of HIV/AIDS treatments. A pilot project was launched through a novel "task shifting model" whereby nurses were trained for extended roles as counsellor, lab technician and outreach worker.

Outcome: Stringent monitoring and evaluation were also implemented, including the supervision of nurses by the PHC Medical Officer and nurse supervisors. In 2009 PHC nurses underwent a qualitative HR assessment: 80 per cent were rated as excellent, while the remaining 20 per cent needed upgrading. A subsequent evaluation indicated more positive results for the programme, particularly with respect to the nurses' roles.

Source: World Health Organisation, 'Interprofessional Collaborative Practice in Primary Health Care: Nursing and Midwifery Perspectives', available at: http://www.who.int/hrh/resources/IPE_SixCaseStudies.pdf (2013)

Case study two: Manchester, England

SITUATION: In the UK, it is estimated that 2.6 million children live with at least one parent or carer who drinks at increasing or higher risk levels, and that over 705,000 children live with a parent or carer who is alcohol dependant.

Parental alcohol misuse has been highlighted as a 'striking' feature in a number of serious case reviews in Manchester by the Manchester Safeguarding Children Board.

ACTION: A nurse-led public health project was launched, with the aim of reducing alcohol-related harm in families and improving access to information and self-help advice to parents and carers across risk levels. The initiative integrates two of the High Impact Changes to reduce alcohol-related harm:

- provide more help to encourage people to drink less through alcohol Identification and Brief Advice (IBA)

- amplify national social marketing priorities to engage higher risk drinkers and nudge them towards lower risk drinking behaviour

The project supports delivery of the Manchester Alcohol Strategy; one of the objectives for 2012 to 2015 is to develop parents' understanding of the impact that their alcohol use can have on their children. The project was planned and delivered over a two-year period, enabling a more comprehensive programme of work to be produced within a limited budget.

Other organisations and services were involved throughout the process of the project such as:

- frontline staff in universal services
- specialist services working with children affected by parental alcohol misuse
- adult services working with parents or carers

Engagement of other organisations and services was managed using existing networks and opportunistic contact with frontline staff at training events, as well as maximising high profile times of the year for alcohol advocacy, for example Alcohol Awareness Week.

As a public health initiative, this project was primarily aimed at parents and carers who drink at a non-dependent risk level, with one in three children potentially affected. The aim was to promote early help, in order to safeguard and promote the welfare of children.

One of the challenges to implementing the interventions has been to shift attitudes of frontline staff away from extreme ends of the spectrum; from alcohol harm, to alcohol dependency syndrome and from safeguarding children, to child protection.

The staff achieved the right balance by listening carefully to the results of our focus groups with staff and parents, and seeking continual feedback on the design and style of the messages produced.

OUTCOME: A number of measures have been used to assess the impact of the project, including:

monitoring web activity

- 939 web visitors and 2,500 page views, in the first six months
- a Twitter reach of 22,000 staff training
- 88 alcohol IBA training sessions delivered to 497 individuals from multi-agency

groups hosted across the city

- messages focused on the impact that parents' alcohol use can have on children, as part of a 'whole family' approach

leafleting

- over 2,000 leaflets were distributed to local organisations and services
- leaflets supported conversations and brief advice around the impact of alcohol on parenting.

Over the long-term, this project aims to support routine implementation of alcohol Identification and Brief Advice (IBA) with parents and carers about their own drinking habits, as part of an early help approach.

The project also contributes to alcohol advocacy, by encouraging the wider health community to support long-term policy changes. This includes:

- tighter restrictions on alcohol marketing and advertising
- ending pocket-money pricing by calling for a minimum unit price for alcohol
- adding Public Health as a fifth licensing objective

Source: Source: RCN, 'Nurses for Public Health', available at: http://publichealth.testrcnlearning.org.uk/home/alcohol/ (2016)

Case study three: Cape Town, Republic of South Africa

Situation: In 2000, the University of Cape Town Lung Institute developed a series of innovative packages to train nurses in rural, underserved areas to lead in screening patients at high risk of TB or other acute/chronic respiratory diseases.

Action: Over a period of 14 years, a randomised trial cluster of 40 clinics with over 200 nurses showed a substantial improvement in early detection of TB. Following this success, a follow-up programme was developed. This extended the training of clinic nurses to include HIV/AIDS screening, referral to doctors for diagnosis and initial prescribing of treatment, with patients then returning to nurses for monitoring.

Outcome: A second cluster of randomised trials for this extended programme again confirmed a substantial positive impact on case detection of TB and HIV. There was also a surprising improvement in successful outcomes for retreatment patients with TB, suggesting that the training had a positive impact on nurse–patient relationships.

The trials also found that that nurse-led care of HIV/AIDS caseloads resulted in patients being managed as effectively as they would have been in doctor-led programmes. Qualitative evaluations alongside these trials also showed that front line clinic staff felt empowered by their training, setting to rest a fear that responsibility for clinical diagnosis and treatment would be overpowering and result in burnout.

Source: BMJ, http://innovations.bmj.com/content/early/2015/07/23/bmjinnov-2015-000045.full (2015)

Case study four: London, United Kingdom

Situation: The Central North West London NHS Foundation Trust (CNWL) worked with nurses at St Mungo's Broadway, London's largest charity for homeless people, to develop a new sexual health outreach service. Satellite clinics were established within St Mungo's hostels in Camden, targeting people who would not normally attend mainstream services. The aim is to empower homeless people to engage with and improve their sexual health.

Action: A multidisciplinary project team was established, consisting of researchers, management and clinical staff. A nurse-led satellite outreach sexual health service was established at three of St Mungo's hostels in Camden. Nursing staff worked with health promotion service, Central London Action for Sexual Health (CLASH) and with St Mungo's to increase awareness of sexual health issues amongst both staff and residents.

Some key points of success were:

- training clinical staff to deliver a nurse-led service, work with a homeless population that includes sex workers and other vulnerable people, and respond appropriately to their complex health needs

- developing referral processes and pathways to manage urgent mental health issues and other medical problems

- working with commissioners to demonstrate the value of the project and ensure that sufficient finances were in place.

Outcome: The number of women starting contraception and the number of men and women screened and treated for Sexually Transmitted Infections (STIs) and Blood Bourne Viruses (BBVs). Interviews with participants and staff from each of the three hostels explored knowledge, attitudes and contraceptive behaviour of the homeless population.

STIs, BBVs and risks for BBVs were identified, enabling treatment and vaccinations to be administered. Prevention of unplanned pregnancy commenced through the use of reliable contraceptive methods and vital cervical screening was performed.

During the first year of the project:

- there were 367 attendances
- 60 per cent of attendances involved interventions
- 59 infections were diagnosed
- 28 female clients attended for contraception or contraception advice
- 95 per cent of attendees rated the service as good or excellent.

Interviews revealed harrowing stories of sexual abuse and risks for sexual ill health, including the use of illicit drugs, barriers to accessing health care services and a lack of knowledge about STIs and contraception.

Source: RCN, 'Nurses for Public Health', available at: http://publichealth.testrcnlearning.org.uk/ (2016)

Leadership and capacity-building

Case study one: The critical role of nurse leaders in tackling SARS, Taiwan (Republic of China)

Situation: Between 2002 and 2003, SARS overwhelmed health care systems and health professionals who had to provide care in situations involving high personal risk and stress. Nurse leaders in Taiwan had to develop new strategies and support systems for nursing care to meet this challenge.

Action: In 2009, the National Yang-Ming University conducted a study which explored the experiences of Taiwan's nurse leaders in fighting severe acute respiratory syndrome (SARS).

Outcome: The study found that nurse leaders (both frontline managers and executive administrators) worked under incredible stress to lead the profession through this period of crisis. The study identified five consistent stages which nurse leaders undertook to effectively combat SARS over 12 weeks. These were: facing shock and chaos; searching for reliable sources to clarify myths; developing and adjusting nursing care; supporting nurses and their clients; and rewarding nurses.

The report concluded that nurse leaders had become important executors of intervention in this health disaster, requiring emotional intelligence to manage internal conflicts and interpersonal relationships effectively. The report also found that they had developed keen socio-political and analytical abilities which proved crucial in planning and implementing strategies where none had previously existed.

The findings will assist nurse leaders to prepare themselves and the profession to better deal with disaster management in similar infectious outbreaks in the future.

Source: National Yang-Ming University, http://www.ncbi.nlm.nih.gov/pubmed/19207797 (2009)

Case study two: RCN's capacity-building partnership with the Zambia Union of Nurses Organisation (ZUNO)

Situation: Following the formal establishment of a partnership between the two national nursing associations in January 2014, the RCN launched a two-year project with the Zambia Union of Nurses Organisation (ZUNO) in April 2015. The aim for both organisations is to share best practice between the two countries and strengthen the voice of nursing associations.

The partnership, which was set up by the RCN's International Committee, is our first institutional capacity-building project with another national nursing professional association and trade union. We are pleased to be able share our experiences as a professional association with ZUNO, who are keen to build on their previous international collaboration work with the Norwegian Nursing Organisation.

The RCN's work with ZUNO will focus on strengthening the nursing voice in Zambia, and ensuring it can push for improvements in nursing policy and practice that will help nurses do the best job they can. The partnership will enable ZUNO to encourage nurses to find their voice as leaders, both in clinical practice and at policy level to take the lead on delivering best practice and high level care. As a vehicle with which we can demonstrate that increased capacity, ZUNO (with RCN support and mentoring) will lead training with hospital staff on use of the WHO safe surgery checklist.

Action: To ensure that this project successfully achieves its objectives, and that the process is as open and transparent as possible, the RCN has set clear indicators around which the project will be measured, including:

- Number of ZUNO staff and representatives trained in advocacy and the development of an organisational advocacy plan

- Level of engagement and consultation with ZUNO by decision-makers in Zambia;
- Endorsement received from key stakeholders and other professional associations in Zambia

- Number of ZUNO members acting as lead advocates on use of the WHO safe surgery checklist at University Teaching Hospital Lusaka

- Number of monitoring and support visits to University Teaching Hospital Lusaka by ZUNO

- Regular communication between RCN and ZUNO to share relevant learning, challenges and successes

Outcome: The RCN and ZUNO have carefully considered the steps needed to ensure that positive outcomes from this partnership are sustainable and last beyond the project's end. We have jointly identified the following actions:

- Lessons learned are clearly documented in a lessons learned log to ensure organisational memory for both RCN and ZUNO

- ZUNO applies its learning to influence policy in other areas of nursing through development of an organisational advocacy plan

- Develop recommendations arising from the project, including the future role of ZUNO in roll-out and support of the use of WHO Checklist

- Develop, in partnership with stakeholders including the Surgical Society of Zambia and the Ministry of Health, guidance for roll-out of WHO Checklist in Zambia, identifying roles of hospitals, professional associations, the regulator and government departments

- The RCN will apply learning to development of any future international partnerships and projects; and will highlight learning and recommendations to UK stakeholders associated with project, and to other partners working in theatres in Zambia and elsewhere

- The RCN and ZUNO will work with and through groups such as the Zambia UK Health Workforce Alliance to highlight the importance of engagement with national nursing associations in partnerships for global health.

Source: Royal College of Nursing

Case study three: RCN UK and international research shows the critical role of 'supernumerary' nurse ward leadership roles

Situation: The Francis Inquiry report (2012) into serious care failures at a Mid-Staffordshire Hospital highlighted the pressing need for empowered ward leaders

with supernumerary status.[17] This means that ward leader posts should be protected from being required to "muck in" with their teams, enabling them instead to focus on managing the team, being a clinical role model, developing and leading the ward team, representing and negotiating the interface with senior management/wider organisation, and being visible for patients and their relatives.

Action: In its 2014 report, 'Not Just a Number', the RCN flagged that the UK Government's focus on reducing the number of these clinical leadership positions had severely diluted their supernumerary component, raising significant risks to patient care, in spite of the Francis report.[18]

A further two pieces of academic research were also undertaken which focused exclusively on the experience of ward leaders.

The first of these took a sample of 22 UK ward leaders who had moved into a supernumerary capacity. This work utilised a series of quantitative and qualitative research methods, and sought to empirically establish that the supernumerary component to a ward leadership role is truly critical to the effective functioning of the ward environment. The final report, 'Stepping In, Steeping Up, Stepping Out' was launched in 2016, and its key findings include:

- Supervisory ward sisters were able to take a holistic view of their role, reconsider and reclaim all the elements of the role, something they reported difficulty with whilst working as part of the "hands-on" team

- Supervisory ward sisters took control of their own use of time, reporting an improved balance between clinical and managerial elements of their work

- Many reported an increased feeling of autonomy and feeling less stressed

- Perceptions of others about the role shifted, with some band 5 and 6 nurses interested in the prospect of a supervisory ward sister role themselves as the supervisory ward sister had given them a vision of their future

- Supervisory ward sisters felt able to take a more effective leadership role, developing staff by being alongside them and managing their team effectively

[17] National Archives, 'The Mid Staffordshire NHS Foundation Trust Public Inquiry', available at: http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/ (2013)

[18] Frontline First, 'Not Just a Number', available at: http://frontlinefirst.rcn.org.uk/blog/entry/more-than-just-a-number-reckless-policy-draining-nhs-of-experience/ (2014)

- By providing a professional role model and setting clear expectations, they empower staff through this supportive/developmental approach and act as a key point of professional socialisation within their area

- Making connecting in the organisation is an important dimension of their role and many supervisory ward sisters gave examples of understanding of the complex elements around frontline performance and making well informed, insightful connections between the ward and the wider organisation.

The second piece of work looked at the experiences of ward leaders in Australia, New Zealand and the United States. This report found that in those instances where the tenets of a supernumerary role were present, care outcomes, systems of succession planning and realistic workloads were often better – corroborating the findings of 'Stepping In, Steeping Up, Stepping Out'.

The final report, 'Frontline Nurse Leadership: An International Perspective' was launched in 2016.

Outcome: The RCN intends to use these findings to lobby the UK Government to invest in more supernumerary ward leadership positions.

Source: RCN, 'Stepping In, Stepping Out, Stepping Up,' available at: https://www.rcn.org.uk/professional-development/publications/pub-005026 (2016) and RCN, 'Frontline Nurse Leadership: An International Perspective', available at: https://www.rcn.org.uk/about-us/policy-briefings/br-0216 (2016)

Case study four: RCN's Clinical Leadership programme, UK

Situation: Nurse leadership has been a long-standing priority for the UK health system. The Department of Health NHS Plan identified the importance of leadership and the necessity of remodelling the NHS around the needs of service users as early as 2000. Following the Francis Inquiry report (2012) into serious care failures at a Mid-Staffordshire Hospital, this theme was reinforced, with Sir Robert Francis calling for strong nurse leaders "from ward to board".[19]

Action: The RCN's Clinical Leadership programme was first launched in 2000, before being reviewed, revamped and relaunched in 2015. It recognises the

[19] Ibid.

importance of quality leadership to the improvement of patient safety, and utilises the RCN's wealth of knowledge and expertise to develop the skills of future leaders.

Individuals develop their clinical leadership skills through action learning sets and coaching, using patient and service user experiences. The programme consists of a four day residential course which includes the assessment and certification required to gain an annual license for delivery. Each participant will be assigned a professional mentor to guide them through the process.

Once an individual has successfully completed the RCN Clinical Leadership Programme they will become a licensed facilitator - enabling them to deliver the programme to others within their organisation or externally. This provides organisations with the opportunity to recoup the cost of training the facilitator.

Participants will:

- lead a service improvement project which will enable them to implement the learnings
- manage the process of change in the clinical environment impacting on patient safety, practice, compassion and care
- experience action learning sets as a supportive personal development tool.

Components of the RCN Clinical Leadership Programme include:

- Six core modules including the preparation day
- Up to six inter-module facilitated action learning sets focusing on supporting and challenging participants
- Service improvement project – work based learning, & supported by work based mentor
- Patient and service user stories
- Observations of care
- Participant's reflective diary/workbook

Outcome: The RCN Clinical Leadership Programme is available to any organisation committed to developing leadership skills among its senior clinical staff and improving patient care and safety. During its first two years, 96 programmes were run within 80 NHS trusts in England and a total of 1,052 clinical leaders and their teams underwent the programme. Reflecting this effectiveness, the first version of the CLP was also exported overseas to nursing teams in Australia and Belgium.

A 2005 review of its effectiveness concluded that the CLP had a significant positive impact on the leadership capabilities of clinical leaders. Overall, clinical leaders were more confident in their leadership approach and showed a greater sense of value

and optimism about their clinical roles.[20] All described an increased commitment to improving care for service users and developing team effectiveness. Reflecting this success, the first version of the CLP was also exported overseas to nursing teams in Australia and Belgium.

The RCN is also conscious that the increasing divergence of NHS provisioning across the four UK nations will require a tailored and context-specific service offering. As part of this, the RCN has also revamped its Political Leadership Programme (PLP) in Wales, in time for elections due to take place in May 2016. In addition, two pilots for a PLP in England are also being planned for 2016

The PLP develops influencing skills and expands the knowledge of participants around how health and social policy is shaped. The programme provides an invaluable insight into the political landscape and illustrates how policy is shaped. It also encourages participants to engage with strategic policy and provides the tools for such engagement.

Source: RCN, 'Clinical Leadership Programme', available at: https://www.rcn.org.uk/workingwithus/leadership-programmes (2015)

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[20] RCN, 'RCN Clinical Leadership Programme: Transforming Clinical Leaders to become Agents of Positive Change', available at: https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2007/october/pub-002524.pdf (2005)