Written evidence submitted by Professor Jennifer Hunt (EPW0004)

Introduction

Information about myself

I trained as a nurse at Guy's Hospital London then undertook a History degree at Bristol University. After completion I was appointed as one of the first group of Research Assistants participating in the RCN/DHSS Study of Nursing Care Project. Since then I have held research posts in university and hospital settings, senior nurse management posts as Director of Nursing at the Royal Marsden Hospital and Chief Nurse at the Royal Brompton Hospital and worked at both the King's Fund and the Department of Health. My last full time post was as Director of the then new Nursing Research Initiative for Scotland, a national unit funded by the Chief Scientist Office of the Scottish Office. In 1999 I returned south to become an independent research consultant and Visiting Professor first at the Institute of Health Research, University of Bedfordshire and more recently at Anglia Ruskin University. Awards include being made a Fellow of the RCN, the RCN (Scotland) Lifetime Achievement in Nursing, Smith and Nephew Research Scholarship, Trevelyan Fellowship, University of Durham and (the first nurse) a Commonwealth Fellowship, Canada

I have served on many national government bodies and professional committees including: the Standing Nursing and Midwifery Committee; the Audit Commission (the first nurse to be a commissioner), the Clinical Standards Advisory Group, the Commission on Human Medicines, the RCN Research Society, the Foundation of Nursing Studies and the Safe Staffing Alliance. More recently I have become a member of the Cambridge Bio Resource Advisory Committee and several of its PPI panels. I have published and lectured extensively. As a senior nurse I served on numerous internal research and management committees.

My research focused on nurses and patient care. I am particularly noted for my work on the utilisation of research findings in clinical practice (for which I was made a Fellow of the RCN), the nursing process and the relationship between nurse staffing and patient outcomes. I have published and lectured extensively. Of particular note among my publications is the Royal Marsden Manual of Clinical Nursing Procedures which was first developed by myself and my senior nursing colleagues during my time there.

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Workforce Commitments Grid: Comments

Government Commitments

A challenge for me in responding is that these commitments are imprecise and open to varying interpretations which impacts on their evaluation. Given my background of substantial research, and of senior and top management experience in nursing I am focusing most on the first.

Nurses are the first group mentioned but with no clear definition of the term 'nurse'. Unfortunately the title 'nurse' is not legally defined. So do they mean Registered Nurses (RNs) or others including Nursing Associates and Nursing Assistants? Without such clarity it's impossible to evaluate whether or not the target has been reached. There is a similar lack of clarity and specificity for what is included under 'other healthcare professionals'.

Including evidence on: **Current levels of staffing.**

What is meant by current levels of staffing?
Funded establishments? Numbers in post? People or Full Time Equivalents (FTEs)? Staffing requirements based on a valid and robust staffing methodology?

Will the evidence include that on safe staffing and the relationship between RN staffing and quality outcomes relating to the patient, the nurse and the organisation? Research shows that better ratios of graduate RNs to Patients results in better outcomes. Such evidence has been accruing for at least 40 years and now is very robust. The benefits of a graduate workforce however are still challenged. Sadly the evidence has not been implemented by government, policy makers or managers. My personal experience of working at the Royal Marsden Hospital in the 1980's (which at that time came close to achieving a fully trained RN workforce in all clinical areas) meant I actually experienced the benefits of that approach.

I do not know if other health care professionals have a similar level of evidence to support their staffing numbers. What is clear is that there appears to be less opposition to having a graduate workforce for physiotherapists and radiographers etc. than for nurses.

Target of 50,000 more nurses

Why 50,000 apart from the fact this is a headline grabbing figure? Again from what baseline? Is this to be over and above:

- Current levels of nurses in post or funded establishments?
- Does it take into account the losses due to nurses retiring or no longer wishing to work in nursing? Recent data show that almost as many nurses from the UK left the Register (11,668) as joined (13,078).
- Is it to be 'new' nurses only?
- There is no mention of whether, and if so how, sufficient university or other recognised nurse training places will be funded to achieve such a substantial increase in new graduates from the UK. Where will these nurses come from?

Does anyone know the most cost effective ways to increase numbers? If not are there plans to determine what they are? Personally I would be looking at prioritising those which incur the lowest cost and take least time namely:

- attracting back qualified nurses of working age who choose to work elsewhere by identifying why they left, providing back to nursing programmes and improved flexibility in their working conditions
- providing tailored training and support programmes to newly qualified staff to reduce the high attrition rate of newly qualified RNs
- reducing leaving rates again by focussing on improving flexible and supportive working conditions.
- short courses for graduates with non nursing but appropriate degrees

Building a skilled workforce

Again the Government commitments are so vague and imprecisely worded that it is very difficult to determine if they are being met. For example under *Commitments* what does 'help ' mean?

There is an emphasis on digital records. Such records can be very useful but the commitment to their value does not appear to have any evidence to support it. They are very dependent on accurate and timely input and a glance at any such records demonstrates that this is not always the case. They also can be time consuming to complete. Their development by IT experts can mean that they do not meet the needs of patient facing staff, patients and carers and different systems do not talk to each other. Last but not least access may require Wi-Fi which is not always

available in hospitals, the community and peoples' homes. Patients, staff and service users who do not use electronic devices or wifi will be disadvantaged.

Wellbeing at work

The focus is on new services. Is their data identifying what new services are needed and why. What about existing service and the extent to which they are currently being provided – or not?

I would wish to see a commitment to ensure the availability of what I would call essential wellbeing support namely:

- Healthy food at reasonable prices 24/24
- A staff restroom for each ward/department
- Water, tea and coffee etc. available for each ward/department
- Enforcement of contracted meal breaks
- Limits on unpaid overtime or payment of all additional hours worked
- Affordable nursery and child care availability
- Exercise facilities
- Changing rooms and on site laundry to improve infection control
- Affordable car parking or hospital transport or reduced fares with local transport providers.

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