

# Where have all the nurses gone?

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## KEY WORDS

UK, policy, NHS

## ABSTRACT

### Objective

The aim of this article is to highlight a crisis that has developed in UK nursing.

### Setting

The nursing workforce worldwide is diminishing and the UK nursing workforce is no exception.

### Subjects

Registered Nurses.

### Primary argument

While steps are being taken in the UK to alleviate the nursing shortage by funding more places in university nursing departments, this initiative is no longer viable due to the financial crisis in the NHS, which funds nursing education. The significant influx of international nurses to the UK is likely to be a short-term solution to a long-term problem as this incipient form of neo-colonialism is seen to deplete developing countries of their nurses, and international nursing bodies condemn it.

### Conclusions

The outcome of the crisis may well lead to the disappearance of nurses from the UK NHS workforce as they are replaced by the cheaper alternative of health care assistants and technicians. This can only be to the detriment of patients.

*It is the year 2012, somewhere in England. Jimmy, aged 4, has fallen off his bike and broken his arm. Liz, Jimmy's mother, has put a splint on his arm, arranged for Rob, her partner to come home from work early to mind the other children, and is taking Jimmy to the hospital. On arrival at the emergency department (ED), they are greeted by a clerk, who decides that Jimmy is a trauma patient and sends them to the trauma centre. There they are seen by an emergency department practitioner, who orders an X-ray, which is taken by a radiographer. Jimmy's arm needs pinning, on return to the ED, he is prepared for the operating theatre by the health care assistants who work there. Liz is told that she must stay and care for Jimmy after he comes back from theatre, and is told how to do the observations.*

*Jimmy and Liz are taken to the operating theatres by a porter, and are left in the care of a volunteer worker who stays with them until Jimmy is taken into the theatre. Liz wanted to accompany Jimmy until his anaesthetic took effect, but is told she cannot, as they do not have any staff to assist and support her. Jimmy waves to his mother as the porter rolls his trolley into the operating room, where the porter lifts him onto the operating table. Liz heads back to the ward to wait, worried that she has forgotten what she was told about how to do Jimmy's observations afterwards.*

*During surgery, the surgeon is helped by two operating department practitioners, one who is scrubbed and passes the instruments, one who scouts and assists with instrument and swab counts and the numerous other tasks required. An anaesthetic technician assists the anaesthetist with the gas administration, machines, drugs and intravenous lines. Once the operation is finished, Jimmy is wheeled to the recovery room, where another anaesthetic technician supervises several health care assistants, and who stand by Jimmy's trolley until he is fully awake. Jimmy is then taken to the ward by a porter.*

*Liz is waiting for him, and is told by the health care assistants who staff the ward that she must stay with Jimmy as the observations are easy to do and if there*

*are any problems they will call the registered nurse who is in charge of the four children's wards.*

*The next afternoon, after being seen by the doctor, Jimmy is discharged and goes home. During his whole hospital experience, he and Liz never saw even one nurse.*

By 2012, this scenario could be real. In the United Kingdom, nursing roles are being taken over by technicians, assistants with minimal education, and ancillary health staff such as porters. Similar action may be occurring in other countries however the situation is more acute in the UK because of the exigencies of funding and philosophies underpinning the National Health Service (NHS) (Shields and Watson 2006). The NHS is an idealistic scheme, introduced in 1946 when the end of World War II provided an opportunity to redress some of the inequities inherent in British life at the time, such as unequal access to high quality health care and education (Kynaston 2007). Under its socialist principles, all Britons (and many visitors to Britain) are entitled to all levels of free health care, from routine immunisation to liver transplantation. Taxation and national insurance payments (which are, in effect, an extra tax similar to the Medicare levy in Australia) provides the funds.

When the NHS was established however, no-one could have foreseen the exponential development of health care technologies, longer life expectancies, life saving drugs and techniques, increasingly high public expectations fed by communication technologies such as the internet, and the costs associated with all of these. But, as our vignette illustrates, the largest section of the workforce, that is nurses, may be endangered by current UK government policies toward health and the NHS. The aim of this paper is to provide Australian nurses and policy makers with information about nursing in the UK so that informed choices can be made in Australia about policy, practice and models of care. At present, governments and health policy makers are looking to the UK and the NHS for models which may appear efficient ways of using the health dollar (Department

of Human Services 2008). However caution is urged as the evidence presented here gives a different picture to that often perceived by visitors to the UK, who may not understand the nuances and long term effects of the programs under examination as appropriate for Australia.

### **The need for the highest standards of education**

The number of nurses graduating from UK universities with a degree at the point of registration remains at approximately 6% (Sastry 2005); the majority of nursing education is delivered at diploma level. Nurses need the highest standard of education possible, as the legal responsibility for nursing care lies solely with the registered nurse. It has been demonstrated in the United States of America (USA) that in a nursing workforce where the majority of nurses have at least a bachelor's degree, mortality rates are better than in health services where most have lower qualifications. In a controlled study of over 27,000 hospital admissions in Pennsylvania, the odds of 30-day mortality and failure to rescue were 19% lower in hospitals where 60% of the nurses had bachelor or higher degrees than in hospitals where only 20% of nurses had degrees (Aiken et al 2003). Educating nurses to the highest standard is better for the health of all and is cost effective. If the minimum requirements for nursing education and qualification are compared with the extremely rigorous and high standard required to be a commercial airline pilot (Pilot Career Centre 2007) there is a considerable difference. Consequences of low education standards for both professions are similar. If an airline pilot makes a mistake, people die, and similarly with nurses. Why then, are government, the general public and the nursing profession itself happy to accept low standards of education for nurses?

### **Why keep nursing education at such a low standard?**

There is a paradox in nursing education as it is presently constituted in the UK. At one level, nurses' roles are expanding and their levels of responsibility are increasing. However their education may not fully prepare them for these new roles and responsibilities. Nursing education in the UK is delivered at a very low

level, despite being located in universities. The low number of degree educated nurses (Sastry 2005) means that nursing output from UK universities is at a level of very basic education, nurses having undergone a competence or skills based curriculum. The competence and the skills are highly desirable, however the higher order skills engendered in degree level education - decision-making, critical thinking and research skills - are severely lacking. There is a media fuelled public perception that nurses do not need these skills and this is entirely wrong; in fact, they are needed more than ever in the rapidly changing world of modern health care, and especially with advanced and extended roles.

At the other end of the educational process, it is likely the general public would be shocked at the low educational level of achievement of some of the people who are entering nursing programs. Some students have very poor numeracy skills (Hall et al 2005, BBC News 2000), and others struggle with literacy; they would certainly not gain entry to regular university programs. Why should they be admitted to nursing programs? The way nursing students are funded by the NHS creates ethical dilemmas for the educators. As universities are paid by the number of students who finish, there is a danger that universities could be tempted to lower assessment standards to ensure as many students as possible graduate.

UK universities are pawns in the game of balancing supply and demand in the UK nursing workforce. At one point recently they were encouraged to admit increasingly large intakes to provide enough nurses for the NHS (Buchan 2005). This has led to annual intakes in the hundreds with multiple intakes, classes divided in two and lecturers having to deliver material up to four times in a year - it has become a treadmill for many staff who are suffering high levels of stress while still being expected to perform on the research and publication front like any other academic member of staff (Watson 2006). Once the nursing workforce crisis was perceived to be solved, the NHS started cutting back on its commissioning for student places and the universities were then left with too many staff whom they could not easily dismiss (Council

of Deans and Heads of UK University Faculties for Nursing and Health Professions 2007). In fact, it could be argued that UK universities are currently being punished for their success in helping the NHS solve its recruitment crisis.

### **The inequities of the student grant scheme: diploma or degree?**

Nursing students receive funding from the NHS in the form of a grant to cover their living costs and associated costs of education at university. If a student is undertaking the nursing diploma course at a UK university, they are paid much more than a student undertaking a degree, even though the degree program is a year longer (NHS 2007). The amount paid to students undertaking a degree is almost half that given to students studying the diploma program, even when additional allowances are added in; for example,

the 'additional weeks allowance' for students on a course that lasts longer than 30 weeks (table 1). If one examines the maximum amount which can be paid to a degree student, inclusive of all allowances (and extra payment for the 13 weeks to complete an academic year over the allowed 30 weeks), it comes to £8,766 for one year. However a diploma student, given the same conditions, will be given £11,278. The degree program grant is means tested; the diploma grant is not. When the students graduate, the graduates with degrees attain no better jobs and are paid no more than their diploma educated colleagues. This whole scenario is discriminatory, and is a disincentive to read for the degree, though as we have seen before, a degree educated nursing workforce is directly associated with a decrease in mortality in hospitals (Aiken et al 2003).

**Table 1: 2007-2008 NHS bursary rates for new students (in pounds) (NHS 2007)**

<b>PAYMENT</b>	<b>Diploma</b>	<b>Degree</b>	<b>/ year<sup>b</sup></b>	<b>Total<sup>d</sup></b>
Live in parents' home	6,372	2,231 <sup>a</sup>		
Lodge elsewhere	6,372	2,672 <sup>a</sup>		
Live in London	7,443	3,215 <sup>a</sup>		
<b>Additional weeks allowance<sup>c</sup></b>				
Live in parents' home		52	676	2,907
Lodge elsewhere		78	1,014	3,686
Live in London		100	1,300	4,515
Older students' allowance*	715			
<b>Dependent's allowances</b>				
Spouse, partner, 1 <sup>st</sup> child	2,218	2,510		
Each subsequent child	512	512		
Parents learning allowance	1,050	1,239		
Initial expenses	55			
Means tested	No	Yes		

\* for continuing students only in 2007-2008

<sup>a</sup> this allowance is for the first 30 weeks

<sup>b</sup> this is calculated at the weekly rate x 13 (study weeks remaining in year)

<sup>c</sup> this payment is for courses longer than 30 weeks per year

<sup>d</sup> = a + b

### **Training others to do nurses' jobs**

At present in the UK, nurses are actively engaged in an egregious undermining of their own roles (and by and large, they are doing it themselves) (Shield & Watson 2007). Historically, technicians of various sorts, such as Combat Medical Technicians (Army

Medical Services 2008), who are trained to do 'bits' of nursing roles, were often used by the military, where conditions, needs and requirements have always been different to those in the wider health care world. With the downturn in finances of the NHS, and the shortage of nurses, technician roles are being rapidly

developed in civilian services and it is nurses who are educating them (Shields and Watson 2007). The money used to educate and employ technicians would be better spent in higher standards of education for nurses, redesigning nurses' work roles and workforce management (Aiken et al 2001) and making nursing a more attractive career choice by improving rostering systems, creating flexible workloads, providing career development opportunities, and benefits such as free, twenty-four hour child care. Of course, pay is an issue, especially so in the UK, where recent pay increase offers did not meet increased inflation levels (BBC News 2007a), were considered insulting, and did little to encourage young people to choose nursing as a career, nor to prevent nurses leaving the profession (Council of Deans and Heads of UK University Faculties for Nursing and Health Professions 2007).

#### **The nursing shortage, ethical recruitment and job losses**

There is a shortage of nurses worldwide and almost every country struggles to find nurses to staff health systems. Developed countries have been recruiting nurses from developing countries, offering them Western lifestyles, career development opportunities and much more money than they could possibly earn in their own countries. The International Council of Nurses has strongly objected to such practices, as they deplete the nursing workforce in developing countries, where health and health care are usually poor and where all the nurses are needed (International Council of Nurses 2007). The UK has been one of the major recruiters of such nurses. Since 2001, 40,000 nurses have come from outside the UK, with mostly from the Philippines, South Africa and India (Bach 2004). However with the recent downturn in NHS fortunes, the nurses recruited to the UK are under threat as job losses occur. With 22,000 nurses losing their jobs across the UK in the eighteen months leading up to April 2007 (BBC 2007b), nurses brought from developing countries to fill gaps in NHS staffing must be carrying a huge emotional burden of insecurity.

With recent job cuts across the UK, new graduates

have not been able to find work. In some places, nurses are being invited to come to health facilities and work for nothing (Staff and Agencies 2007a) or as health care assistants 'so they won't lose their skills' (Staff and Agencies 2007b). No matter how desperate nurses are for employment, the unethical situation in which they would find themselves makes this a very dangerous situation for any registered nurse. How would a nurse react if, under the code of practice of the UK Nursing and Midwifery Council and all codes of ethics of the nursing profession itself, he or she finds him or herself in a situation where their clinical skills are required but because they are working for nothing they have no legal stance within the health service? For instance, a nurse in a babies' ward may see an IV going much too fast. Even though he or she knows that the baby is in danger of potentially fatal fluid overload, if the nurse is working as a volunteer, he or she will have no legal cover and will be working outside the law if he or she tries to adjust the IV. There are many such examples which could be described, but the whole situation is such an ethical, legal and moral minefield that it is incredible that the health services contemplated such actions in the first place.

#### **The role of health care assistants**

The past decade or so in the UK has seen an increase in the status and role of health care assistants (McKenna et al 2008); as nursing roles have expanded so have those of health care assistants. This rise of other health care worker roles has been concomitant with accommodation for the time nurses have to spend on what would once have been seen as duties beyond their nursing role. Examples of such roles include specialist and advanced practice and consultancy roles; all labelled to give nurses the feeling that their status is increasing when, in reality, these roles are often encroachments into the medical domain, designed to compensate for the tasks which the medical profession are divesting, as their own roles expand due to increasing technology and medical and surgical possibilities. Therefore the 'slack' in this system has been taken up by health care assistants as they take over the so called 'basic'

or 'routine' tasks that were once the preserve of the qualified nurse. Such 'basic' and 'routine' tasks are easily learned and performed by anyone, especially in the era of automated devices for monitoring vital signs. However what health care assistants are not educated to do is to understand and interpret vital signs; nor to observe and assess patients while they undertake the 'basic' procedures. Moreover, taking away these tasks from nurses obviates many natural opportunities for interaction and therapeutic communication. The rise of the health care assistant - at one time called the auxiliary nurse, assistant nurse or nursing assistant - has been paralleled by them seeking their own autonomy and recognition; they now have their own professional journal, and there is a danger that this body of the health care workforce will no longer be accountable to the nursing profession.

## CONCLUSION

Nursing in the UK is in trouble, and unless the problems are addressed soon, it stands in danger of disappearing, to be replaced by technicians of all kinds, health care assistants with minimal education and non-educated health care workers. All British citizens will be disadvantaged if this occurs. As the NHS struggles to meet budgets, to provide the highly technological health care demanded by a media-savvy public, and to give a high standard of costly health care, nurses will be replaced by those with a lower education at a lower cost. This has begun, and nursing in the UK, which used to lead the world, is in danger of slipping to an even lower standard of education and preparation for practice than many developing countries.

All nurses in the UK need to speak out; to use their professional organisations to fight for them; and to lobby politicians and policy makers to ensure nursing does not either slip any further, or disappear altogether (Shields and Watson 2007).

- UK nursing education should be funded to make it more attractive to undergraduates
- The value of nursing care in the UK needs to be investigated by research

- Entry standards to nursing programs need to be raised

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