contact care. Nurses, midwives and health visitors are contributing to integrated health and social care programmes for vulnerable children and adults. All these changes are supported by *Liberating the talents*,[2] the strategy for nursing in primary care which is being taken forward by primary care trusts all over the country.

Each of these strategic developments will have a significant impact on the work of hospital based doctors and nurses, creating new challenges, changing professional roles and the way clinical teams work together. Making the best use of these developments will mean patients, their carers and families directly experience the real benefits.

It is up to clinicians and interdisciplinary teams to work together at a local level to make this happen. It is clear that new approaches to interdisciplinary working need to be developed – approaches that focus care around the patient rather than traditional professional roles. This will mean greater involvement, greater choice and greater control for patients, their carers and families as improving the patient experience continues to be a common driving force for change across all NHS services.

References

1 Department of Health. *Making a difference*. London: DH, 1999.
2 Department of Health. *Liberating the talents*. London: DH, 2002.
3 Department of Health. *The NHS plan*. London: DH, 2000.
4 Department of Health. *Agenda for change: modernising the NHS pay system*. London: DH, 1999.
5 Department of Health. *The essence of care*. London: DH, 2001.

A clinical nurse specialist's view

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I was interested to read the article by the Chief Nursing Officer, outlining the directions of nursing in the UK. I came into nursing many years ago and have witnessed many changes in nursing and the NHS, both good and bad. I was one of the 'traditionally trained' nurses, where little time was spent in the classroom and the majority of learning took place in the practical setting and followed the medical model of care. The old adage about a nurse being the doctor's handmaiden to do his bidding probably sums up the general approach when I first entered the profession.

Although I applaud the success achieved by the recruitment campaign, there is still a great deal to do. In some areas and specialties, recruitment and retention is still difficult. Many areas still depend on bank and agency nurses to attain the required staffing levels, and this often leads to a lack of continuity of care.

Recent changes in the curriculum for nurses in training have enabled students to be exposed to 'the real world' of nursing at an earlier stage, and this has encouraged them to take a more active part in the care of the patients. As with any practical placement, this has implications in both time and resources for the staff who support and mentor them. Overall, though, the feeling is that this has been an improvement in nurse training and that the students are better prepared for qualification.

Post-registration education plays a major part in the continuing development of the nurse and is supported mainly by the employing trust, both financially and in terms of protected study time. One of the issues is the lack of standardisation of support for education across the NHS; for example, some areas will support second degrees while others will not. This variation needs to be addressed.

As a senior nurse in the NHS, the issue of consultant nursing posts is quite emotive to me, as to many others at the same level. Access to consultant nursing posts often depends on the priority given to it by the employing trust. Many nurses fulfil the consultant nurse criteria but, due to the financial implications, have not been successful in securing funding for the post. This has left some nurses feeling frustrated and therefore they look elsewhere for positions. The aim of the report, *Agenda for change*,[1] is to develop a modern career framework for nurses and it should

address some of these issues. However, nurses fear that it will cause the same amount of disruption as caused by clinical grading when it was implemented. Some nurses are worried that they may not benefit from the changes, despite reassurances. Also, the increase in annual leave allocation may create problems in maintaining adequate staffing levels.

There have been great improvements in terms of improving working lives: excellent staff-friendly policies have made a real impact on the quality of life for nursing staff, and this should reduce levels of sickness leave and absenteeism. Flexible working patterns have also allowed more nurses to return to work.

A great deal of work has been done on setting standards of nursing care and on benchmarking aspects of care. The initiatives and ideology that underlie the process are laudable, but we still hear of shortcomings in care, from within the profession, and from medical colleagues, the media and users of the NHS. The introduction of the 'modern matron' was heralded as part of the movement towards maintaining standards, but in reality such matrons are often used as bed managers or fulfil other managerial roles.

More nurses now are leading organisations and/or have a more prominent role in service delivery. One of the most worthwhile initiatives in the drive to improve their leadership skills has been the development of the Leading Empowered Organisations programme. Having done the programme, I fully endorse it and have been given the opportunity by the trust to use the skills gained. One of the problems of such programmes is that, despite having attended the course, the opportunity to use the relevant skills is often left to the discretion and philosophy of the employer.

The nursing profession has continued to develop and in some ways bears little resemblance to the role I envisaged when I first came into nursing. Driving this are the changing needs of the health service. The CNO's 'ten key roles for nurses' has outlined the way nursing is developing.[2] Many of the roles identified have previously been the domain of medical colleagues; for example prescribing, ordering diagnostic investigations and minor surgery. However, it is essential that the perception of nursing is not devalued; a nurse prescriber was recently asked by a patient if she was now a doctor. Patients' perceptions of nursing and nurses are often related more to the historical idea of nurses than to reality. Difficulties accepting change are not confined to patients: many nurses still resist the expansion of responsibilities because they see it as devaluing the nursing role and think that they would be taking on the work of the doctors. In my experience, however, doctors have welcomed the expansion and have supported the changes in practice.

As the role of the nurse evolves, the need for clinical supervision becomes more apparent. Clinical supervision in nursing is not yet mandatory, as it is with midwives, and is often seen as unimportant by nurses and employing authorities. It is often ad hoc and informal, and comes low on the list of priorities. As nurses take on responsibilities that were not traditionally within their remit, should clinical supervision become mandatory to support them in their practice?

As I look back at where I started in nursing and how nursing has evolved over the last few years, I no longer think about the good old days but about the exciting prospects for the future. Nursing as a profession has further to go. Basic care of patients should still be the foundation on which to build and should never be forgotten; but the use of appropriately trained staff, whoever they are in the NHS, will ultimately improve patient care.

References

1 Department of Health. *Agenda for change: modernising the NHS pay system.* London: DH, 1999.
2 Department of Health. *The NHS plan.* London: DH, 2000.