Published Online 25 February, 2014 – T J Ryan Foundation
(http://www.tjryanfoundation.org.au/)

Lessons from the UK for Queensland Health: Linda Shields

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Created: 25 February 2014

Queensland is in the throes of change across its public service, and no-where is this more visible than in health.

BEWARE THE CULTURAL CRINGE: RAMIFICATIONS OF THE MID-STAFFORDSHIRE SCANDAL FOR AUSTRALIAN NURSING

Introduction

Health managers and professionals are being brought from the United Kingdom (UK) and the National Health Service (NHS) to work in Queensland public health facilities. It is very good that they come to Queensland and experience the wonderful health services on offer, from which they can take lessons back to the ailing NHS, however, they must find themselves at a disadvantage when they learn that Queensland's (and Australia's) health systems are very different to those in the UK. In addition, the status and education of health professionals, in particular nursing, is very different.

Using the recent Mid Staffordshire scandal as a reference point, this paper provides information about how the Australian health systems, and nursing, work, for the edification of those from the NHS who are arriving to work in Queensland's health facilities. As well, the paper holds a salutary warning for Queensland and Australia. The Mid Staffordshire catastrophe holds important lessons for all, and is a timely warning, given the changes across Queensland, that if health management and nursing go down the same route as the NHS, then the system here could similarly fall apart, to the detriment of the people for whom the system is meant to care.

Background

At a clinical level (that is, direct patient/client care) Australian nurses contribute significantly to the betterment of health outcomes, with clinical practice and education leading to the highest standards of delivery of health care, and Australian nursing research influencing the way people are cared for in health services to the advancement of health outcomes across the world.

In the UK, the Mid Staffordshire Trust (the term used for administration districts within the UK's NHS) has been the centre of a major scandal around patient care, and much of the blame has been laid on the nursing profession. This paper explores the Mid Staffordshire scandal, how nursing was partly to blame and discusses its ramifications for nurses in Australia, and Queensland. At present, under changes brought about by the current Queensland government, some senior level appointments are being filled by recruits from the UK, and the NHS. These people, new to the Australian and Queensland systems, are in danger of having their positions (and decision making that affects both health service delivery and patient/client care) compromised, unless they understand that the Australian and Queensland systems are very different from those in the NHS. Such discussion will enable those coming from the UK to work in the Australian health system to learn about nursing here, enabling them to understand the differences they will encounter when they work with Australian nurses.

The paper provides educative comparisons about the way the Mid Staffordshire scandal has affected nursing in the UK, and the ramifications for nursing in Queensland, so decisions relating to nursing, made by people new to Queensland, can be informed and well balanced. Significantly, it provides two contrary warnings for Australia:

1. Australian nurses must not succumb to the "cultural cringe". They must embrace the leadership role they hold in the world and not look to other countries, under the mistaken belief that anything from overseas is better than at home; and (more importantly)

2. it is incumbent on all to learn about the factors that caused the Mid Staffordshire disaster, and so guard against complacency.

While not on the scale of the catastrophes that are occurring in the NHS at present, (although the scandal about the surgeon, Dr Jayant Patel, in Bundaberg in Queensland (Smail, 2013) must come close) things have gone wrong in Australia, and nursing must remain cognizant that if standards slide, as happened at Mid Staffordshire, catastrophes on a similar scale could easily happen here, to the great detriment of patient care and the wellbeing of the health of Australians.

Nursing in Australia

Until the 1980s, all nurses in Australia were "trained" in hospitals (the word now, in Australia at least, is "educated"). The move to university education and a Bachelor's degree for registration came about with the recognition that health care was becoming highly technological, that drugs and treatments were increasing in complexity, and that multifaceted management systems were being developed to administer health services. It was apparent that, to provide the best care to patients in such new environments, nurses needed to learn far more than in the past, with sciences such as biochemistry, physics, pharmacology, detailed anatomy and physiology needed, as well as social science subjects such as psychology, sociology, philosophy, law and ethics. In addition, nursing was beginning to formalise and generate its own knowledge base and evidence, through comprehensive research into everything that could improve the delivery of nursing care and concomitant patient outcomes. Such an array of necessary knowledge could be obtained at universities only. Of course, clinical application is the point of the exercise, and so nursing degree programmes developed that were (and still are) about 50% direct clinical work.

As with other health professions, specialisation is now required, and many nurses focus their postgraduate work in a particular area. For specialisation, postgraduate study is obligatory, and this is also true for generalist nurses who move upwards through the well embedded nursing career structure. Consequently, Australia has one of the most highly educated nursing workforces in the world, with a high proportion holding Master's and doctoral degrees. This bodes well for patients and clients of nursing, as recent research from Australia and the United States of America (USA) demonstrates that a highly educated nursing workforce produces good patient outcomes and lowers mortality rates in hospitals (Aiken, Clarke, Cheung, Sloane & Silber, 2003, Twigg, Duffield, Bremner, Rapley & Finn, 2013)

The UK National Health Service

The NHS was begun in 1948 as a way to provide health care available to all, free at point of delivery, and paid for out of taxation, meaning that citizens would pay according to their means (National Health Service, 2013). At that time, health care and medicine was far less complicated than now. Transplants did not exist, nor much other technology-related medicine. Complex management systems did not drive hospitals, and the range of treatments and drugs was nowhere near as vast as it is today, indeed, penicillin had been available for only three years (Porter, 2003). Hailed as a wonderful social experiment, the NHS became ingrained into the psyche of all Britons. In fact, in the opening ceremony of the 2012 Olympic Games in London, the NHS figured heavily in the entertainment programme. Its reputation as a fair and equitable method of health care delivery has been lauded around the world (Dixon, Le Grand, Henderson, Murray & Poteliakhoff, 2007). However, the NHS has reached the point of collapse. In 1948, no-one could have foreseen the burgeoning of technology that so characterizes health care today, and no government, however well intentioned, could ever have planned for its blow out in costs.

Imminent implosion is illustrated in a plethora of scandals within the NHS that have rocked the UK. While the media have had a field day, a raft of reports, inquiries and investigations are demonstrating how this venerated social institution is collapsing.

The Mid Staffordshire Trust

Health service districts are known as "trusts" in the UK. "Foundation trusts" are those who have been granted a degree of autonomous management and financial control (Monitor, 2010), and in the early 21st Century, many trusts aimed for "foundation" status. One of these was Mid Staffordshire Trust, which serviced an area centred on Stafford in England's midlands. It has two hospitals, Stafford and Cannock Chase, and provides general practice and a range of community and primary health care services for 320,000 people (Mid Staffordshire NHS Foundation Trust, 2013).

In 2007, the Healthcare Commission (HCC) became aware of high mortality rates at the trust, which, between 2005 and 2008, were almost a quarter higher than normal ((Health Care Commission, 2009). An inquiry was set up and 103 patients and relatives contacted HCC, of whom 99 were critical, or had had a poor experience during admission to one of the trust's hospitals. The main areas of concern were the emergency department, the emergency assessment unit, three medical and some surgical wards. The major concerns of patients and relatives related to poor standards of nursing care. In March 2009, the HCC published a report into the severe failings in emergency care provided by Mid Staffordshire NHS Foundation Trust between 2005 and 2008.

To supplement this inquiry, two reviews were commissioned. One, by a respected surgeon, Professor Sir George Alberti, (Alberti, 2009) who was the National Clinical Director for Emergency Care, examined the hospital's procedures for emergency admissions, and treatment and progress, against the recommendations in the HCC's report. The Alberti (2009) review was largely about medical services, but found that nursing was understaffed, with health care assistants (HCA) constituting half the so-called "nursing" staff.

He recommended that there should be six registered nurses (RN) to every four HCAs, and that they should be "… supported to have the time and opportunity for further training and skill enhancement" (Alberti 2009, p14).

The second review, by Dr. David Colin-Thome (Colin-Thome, 2009), National Clinical Director for Primary Care, reviewed how the trust's commissioning and performance management system failed to expose what was happening in the hospital. Colin-Thome wrote "A central theme of the failures at Mid Staffordshire hospital trust appears to be an over reliance on process measures, targets and striving for Foundation Trust status at the expense of an overarching focus on providing quality services for patients. Targets and process measures have their place, but they must be considered as a set of tools for improving the quality of care provided" (Colin-Thome, 2009 p5). He made recommendations covering four areas:

1. Involving patients and the public

2. Commissioning for outcomes supported by excellent use of appropriate data and information

3. Ensuring governance and clarity of accountability of all the different organisations in the system

4. Clinical leadership" (Colin-Thome, 2009, p6).

Several things happened following the HCC report and the two reviews (Francis, 2010). Firstly, and in line with the recommendations, there was a net gain of 46 nurses and 51 HCAs across the trust. The number of "matrons" (the archaic term used in the UK for middle level nursing managers) was increased from three to 12. However, recruitment stopped due to financial pressures, though 40 nurses were still needed. A steering group was set up for emergency care, training for junior doctors increased, clinical early warning systems for the deteriorating patient were implemented, training was provided on equipment, new beds were provided, an extra operating theatre was opened, and a tracking system for incident reporting was set up. Then, Mid Staffordshire NHS Foundation Trust invited people with concerns about the care they or a relative received at the trust to request an independent clinical review and on 21 July 2009, the Secretary of State for Health announced an independent inquiry. This last inquiry demonstrated very clearly that despite the recommendations of the previous reports, little had changed. In the letter to the Health Minister in the preface of the preliminary report (Francis, 2010), the chairman of the inquiry, Robert Francis QC, stated "the overwhelming number of accounts given by those affected should surely put to rest the views, still harboured by some, that the Healthcare Commission's report painted an unfair picture of how the Trust was performing. There can no longer be any excuse for denying the enormity of what has occurred" (Francis, 2010, p3).

The full and final report was published on Wednesday, 6 February 2013 (Francis, 2013). This inquiry took evidence from representatives from the Mid Staffordshire Trust, and its Primary Health Care Trust and Strategic Health Authority. It used various documentary material, primary material from the HCC audit, 966 members of the public, 82 staff, past and present, professional bodies, and patient interest groups. The final results were summarised in the preamble letter to the minister of this report, stating that the Mid Staffordshire Trust had:

- A culture focused on doing the system's business – not that of the patients;
- An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
- Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
- Too great a degree of tolerance of poor standards and of risk to patients;
- A failure of communication between the many agencies to share their knowledge of concerns;
- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
- A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation". (Francis, 2013, p10).

While medicine and doctors were said to be partly to blame for the problems found, nursing and nurses were held to be most at fault. When one reads the list of complaints and discrepancies found by all the inquiries and reviews, it is apparent that nursing was deficient in its delivery of nursing care. That said, it is of note that there is nowhere in any of the reports where nurses and HCAs are differentiated. It is not surprising that most of the complaints from patients and families were about nursing, as nurses comprise the biggest proportion of any health service's workforce, and are the health professionals seen most by the public, as it is they who are in attendance 24 hours a day. Nonetheless, given the prevalence of HCAs in uniforms similar to those worn by nurses, it is possible that deficiencies of care could be because of the preponderance of HCAs (who are unqualified and uneducated in nursing, and much cheaper to employ than nurses). As a consequence of the visibility of nurses and HCAs, two pages of the executive summary included recommendations about nursing:

Recommendations of the Francis Report (2013) relating to nursing

1.185 There should be an increased focus on a culture of compassion and caring in nurse recruitment, training and education.

1.186 Practical hands-on training and experience should be a prerequisite to entry into the nursing profession.

1.187 Training and continuing professional developmentfor nurses should apply at all levels, from student to director, and commissioning arrangements should reflect the need for healthcare services to be delivered by those who are suitably trained.

1.188 Nurse leadership should be enhanced by ensuring that **w**ard nurse managers work in a supervisory capacity and are not office bound. They should be involved and aware of the plans and care for their patients.

1.189 The NMC should introduce a system of revalidation similar to that of the GMC [General Medical Council] as a means of reinforcing the status and competence of registered nurses as well as providing additional protection to the public. It is essential that the NMC has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise.

1.190 There should be a responsible officer for nursing in each trust, and they should be accountable to the NMC.

1.191 Consideration should be given by the NMC to introducing an aptitude test to be taken by aspirant registered nurses prior to entering into the profession to explore the candidate's attitude towards caring, compassion and other necessary professional values. Once nurses have received appropriate training, the NMC should ensure the professional development of registrants and should ensure that nurses' training is more practical.

1.192 The special requirements of caring for the elderly should be recognised by consideration of the introduction of a new status of a registered older person's nurse.

1.193 The professional voice needs to be strengthened:

- The RCN should consider how better to separate its trade union and professional representative functions.
- A forum of nursing directorsshould be formed.
- There should be at least one nurse on the executive boardsof all healthcare organisations, including commissioners.
- The advice of the nursing directorshould be obtained and recorded in relation to the impact on the quality of care and patient safety of any proposed major change in nurse staffing or facilities

The Francis Report and nursing

The final report (Francis, 2013) consists of three volumes and 1,782 pages, with an extensive executive summary. Of the listed recommendations, nine are about nursing. These are explained below, not necessarily in order, but placed in relation to their content. Where relevant, comments about each recommendation's relevance to Australian nursing follow at the end of each section. Where such comments are not provided, the observations are generic across nursing in all countries.

Recommendation 1.185

The first nursing-related recommendation states that "*There should be an increased focus on a culture of compassion and caring in nurse recruitment, training and education*" (Francis, 2013, p76).

While indicative of the problems within the Mid Staffordshire Trust that necessitated the inquiries in the first place, that is, perceptions of lack of compassion and caring amongst nursing staff, the implications from this point are more subtle than seen at first. It makes one question what really went wrong. Compassion and caring are not just part of nursing, but its *raison d'être*. Over the last 200 years there has been exhaustive discussion of the role of caring and compassion in nursing, from Catherine McAuley's "Careful nursing" in the early part of the 19th Century (Meehan, 2012) to modern arguments related to education (Guo, Shen, Ye, Chen & Jiang, 2013), patient care (Dewar & Nolan, 2013) and research (Akansel Watson, Aydin & Ozdemir, 2013).

Nurses in all cultures were originally those who cared for the sick, and it is almost impossible to imagine that anyone who enters nursing does not care in some way, with at least a modicum of compassion. Of course, there have been examples of the opposite, with nurses who have killed their patients intentionally, for example, Roger Dean, who, in 2011, set fire to a nursing home killing 11 elderly residents (Box, 2013). Even the nurses who, under the Nazis, actively killed their patients, reasoned that it was more compassionate for themselves, as trusted by and kind to their patients, to do the killing, rather than leave it to a soldier with a rifle butt (Benedict, Shields & O'Donnell, 2009; Benedict & Shields, in press).

To one outside the Mid Staffordshire scandal, this recommendation sounds patronizing and shameful, and it can be surmised that most nurses in the UK must feel this way. The media coverage over this, and others, of the included recommendations has been of the "shock and horror" variety, with little care or compassion for the millions of British nurses who have always given excellent compassionate care to their patients. It is strange that their peak body, the Royal College of Nursing, has not been very vocal on this point alone.

The second part of this recommendation is about the establishment of national standards. Again, it is hard to imagine that this is not in place. The "Knowledge and Skills Framework" (Department of Health, 2004), implemented across the UK in 2004 as part of the policy, "Agenda for Change", a directive for the whole NHS, was supposed to provide national standards for nursing care.

The Australian Commission on Safety and Quality in Health Care was set up by the Federal Health Ministers in 2006, funded by all governments, to lead and coordinate health care safety and quality in health care in Australia. Its work was incorporated into the National Health Reform Act 2011, under which a programme of accreditation of all health care standards was put in place. All nursing in Australia works to these standards, as do all health facilities in Queensland (Australian Commission on Safety and Quality in Health Care, 2013).

Recommendations 1.186 and 1.191

Recommendation 1.186, "*Practical hands-on training and experience should be a prerequisite to entry into the nursing profession",* seems to be related to a recommendation further down the list, 1. 191, which states*"Consideration should be given by the NMC to introducing an aptitude test to be taken by aspirant registered nurses prior to entering into the profession to explore the candidate's attitude towards caring, compassion and other necessary professional values. Once nurses have received appropriate training, the NMC should ensure the professional development of registrants and should ensure that nurses' training is more practical".*

This is another example of the attacks that emerged when British nursing education moved into universities in the 1990s, with the hoary old chestnut that nurses with a university education were "too posh to wash" (Hall, 2004). Government and media have made much of these two recommendations. Jeremy Hunt, the then Minister for Health, said "What nurses on the frontline are saying, a lot of them, particularly the older nurses, is that this was part of nursing training. Why would you want to become a nurse if you were unwilling to spend time washing patients, feeding patients, doing that really vital experience on the frontline?" (Chapman & Martin, 2013) and the Prime Minister, David Cameron, weighed in with "nurses should spend some time when they are training as healthcare assistants in the hospital really making sure that they are focused on the caring and the quality and some of the quite mundane tasks that are absolutely vital to get right in hospital … all nurses in training should spend time caring for patients, is a good step forward" (Triggle, 2013). The main consequence of this recommendation is that persons who wish to enrol in university nursing courses are going to be required to work for a year as a HCA prior to enrolment. It is difficult to see how this will improve the potential nurse's performance with patients. If a nurse is going to gain those attributes, then the skills they are taught during their extensive rounds of clinical placements during the university course (50% of the course of study) should suffice, while the idea of teaching the personal qualities of caring and compassion raises the question of how one does that. It is like teaching someone to love, or to fear. The philosophies and psychology behind such characteristics can be taught, but it is questionable that the qualities themselves can be transferred pedagogically.

Perhaps this is what drives the idea of an aptitude test in Recommendation 1.191; however, these attributes are as difficult to measure as they are to teach, (Bradshaw, 2009) and testing them in an individual is open to manipulation and inaccuracy, rendering such attempts essentially worthless.

From a cost perspective, Recommendation 1.191 would be expensive to implement; conversely, Recommendation 1.186, making candidates for a nursing place at university work for a year as a HCA will save the government many millions of pounds as they can be employed to replace much of the nursing workforce. After all, an HCA is much cheaper to employ than a RN. This smacks of the slave labour of the old "hospital training days" when student nurses made up the bulk of the nursing workforce in a hospital while working for a pittance and the privilege of being trained (Shields, 2013). Such days are long gone.

Australia's nursing students usually work during their education, often in retail and hospitality. In various places, they can join schemes in which students are employed as Assistants-in-Nursing (AIN) in health services that already provide their clinical placement opportunities. Such arrangements ensure their talents are used appropriately, rather than working in fast food chains or other part time employment. At the same time, working as an AIN provides extra exposure to clinical nursing. However, these schemes are not mandatory, and are not preliminary to, nor a requirement for, enrolment or progression in university, nor are they proposed as an integral part of the nursing curriculum.

Recommendation 1.187

Recommendation 1.187 states *"Training and continuing professional development for nurses should apply at all levels, from student to director, and commissioning arrangements should reflect the need for healthcare services to be delivered by those who are suitably trained"*. Such factors are a normal part of health service delivery and this recommendation seems redundant. It is impossible to think that, in either the UK or Australia, these are not in place in any health service, and their inclusion in this report does, perhaps, suggest the reasons why this scandal, with its poorest of care, occurred in the first place.

Given that all nurses and doctors are given (and expected to undertake) ongoing professional development, and those commissioning healthcare services employ those not suitably trained at their peril, then one must think that standards have slipped to truly frightening levels in the UK. Alternatively, it may pertain to the number of unqualified HCAs who were employed by the

Mid-Staffordshire Trust. Health care assistants, with no education or training in health care, can only ever be expected to undertake the most basic of procedures, and what we call "basic (nursing) care" does not come under that label.

In all countries, the need exists for discussion of misconceptions held by many outside nursing that so-called "basic care", such as giving a bedpan, or bathing a patient, requires little skill apart from applying soap and water, or placing a pan under a person and taking it away again. There is nothing "basic" about such procedures. Watson (Shields, et al., in press) suggests that the term "essential" care is more fitting for these complex activities that are so necessary for patient wellbeing. When fully educated nurses undertake such "essential" procedures, they are, at the same time, assessing the patient for mobility, skin condition, physical signs of illness; they communicate with the patient to assess their speech and thought processes to determine any problems the patient is encountering, and personal and family factors that may be affecting the patient's illness trajectory. Until concepts of "essential care" are better understood by policy makers, other professions, and the general public, misunderstanding of the elements of the role of nurses will continue.

Professional development is a requirement of all nurses and is reflected in performance reviews, job descriptions and continuing registration requirements in many countries. The fact that this has emerged in the Francis Inquiry may reflect a deficiency in nursing in the UK. Certainly other recommendations also indicate concerns with how nursing is taught, regulated and overseen there.

Recommendation 1.188

Recommendation 1.188 "*Nurse leadership should be enhanced by ensuring that ward nurse managers work in a supervisory capacity and are not office bound. They should be involved and aware of the plans and care for their patients"* is perplexing.

Once, the causes of the problems that elicited this recommendation would have been easy to understand. There was one "charge nurse (or sister)" as those in charge of wards were known, for each ward, depending on the size of the hospital, a few "nursing supervisors" above the charge nurses, and matron as the single point of responsibility over all. In those days, hospitals were far less complicated places than they are now. Quality improvement systems were in the future, accountability and audit were unknown management terms, separate departments such as infection control, bed management, patient flow, etcetera did not exist, and so on.

Things were simple – a patient presented to hospital, was declared ill enough for admission, was placed in a ward, treated and went home. The charge nurse knew every patient who was admitted, and all nurses got to know the patients during their admission, which usually lasted at least a week.

Today we have very complicated management systems built on risk management, highly regulated human resource policies, much higher admission rates and throughput of patients, much higher levels of patient acuity (those in wards are much more ill than patients in the past), treatment regimens are much more complex, as are drugs and procedures; and most patients are discharged on the same day of admission. Pack all this into a highly regulated environment and the modern hospital and ward is discernible. Some nurse managers do the role of the "charge nurse" and are based in their wards. They, like their predecessors, know all their patients well, and their direct clinical care, as in days past, is the lynch pin that holds the ward together. However, many nurse managers work outside the ward/unit parameter. They are employed in hospital-wide units as throughput managers, or in infection control, or admission planning, to name a few. They may be in charge of a bank of wards, or, in rural areas with small hospitals, have responsibilities across many hospitals. Their work is very different to the ward-based nurse manager, but is comparable in workload and required level of expertise and education (in Australia, most hold Master's degrees). Recommendation 1. 188 – to make them all undertake "bedside nursing" is a nonsense, and one which would be a waste of time and valuable resources. Who is going to do their jobs while they are taking on this “bedside nursing”, which at best would give little added benefit to their performance?

Recommendation 1.189

The regulating body for nursing, the Nursing and Midwifery Council (NMC) (http://www. nmc-uk. org/), comes under the spotlight in Recommendation 1. 189 *“The NMC should introduce a system of revalidation similar to that of the GMC* [General Medical Council]*as a means of reinforcing the status and competence of registered nurses as well as providing additional protection to the public. It is essential that the NMC has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise”.*

It is difficult to understand how 1.189 was included, as the NMC, in its many guises, has regulated nursing since registration was set up in 1860 (Nursing and Midwifery Council, 2010). As explained above, over the last nine years, UK nursing has worked to the *Knowledge and Skills Framework*, (NHS Staff Council, 2010) which describes in detail the scope of practice and education for nurses (Gould, 2007).

The Australian Nursing and Midwifery Accreditation Council (http://www. anmac. org. au/), in conjunction with the Nursing Board of the Australian Health Practitioner Regulation Agency (AHPRA) (http://www. ahpra. gov. au/) ensure a consistent standard of nursing education throughout the country, with national standards applied across all universities and health agencies.

Training and continuing professional development is required for nurses at all levels, and is provided through conference and on-going education programmes. A system of revalidation is in place – all nurses, either registered or enrolled, have to demonstrate each year how they have maintained the knowledge and skills appropriate to their registration/enrolment and scope of practice. All focus on the National Standards (Australian Commission on Safety and Quality in Health Care, 2013) so a consistency in practice, education and care delivery is implemented across the country.

Recommendation 1.190

Recommendation 1. 190 “*There should be a responsible officer for nursing in each trust, and they should be accountable to the NMC”* may serve the NMC well, with a representative in each trust. However, as there are over 100 trusts across the UK (NHS Choices, 2013), the costs of such positions would have to be carefully determined to be sure of their benefit.

Australia’s governing body, AHPRA, has boards in each state, but AHPRA is relatively new because until 2010, each state had its own registration and governing body for each health profession, for example, the Queensland Nursing Council, and the Queensland Medical Board. With Australia’s small but geographically dispersed population, AHPRA fills a long standing need for national registration and regulation of all health professions.

Recommendation 1.192

It is widely recognised that the demography of wealthy countries is changing, with an increasing proportion of the population living into ripe old age, kept alive by advances in health technology and concomitant life style improvements and opportunities. In all such countries, much discussion ensues around providing health care to the ageing population (Corke, Lavery & Gibson, 2005, Shimizu & Inoue, 2013). Recommendation 1.192 *“The special requirements of caring for the elderly should be recognised by consideration of the introduction of a new status of a registered older person’s nurse”* may be a very good idea. There is no argument that nursing care of the elderly is becoming highly specialised, and, in many countries, ignored to a certain extent. Implementation of 1.192 would provide a much needed emphasis on this. Australia would do well to implement this idea, with the proliferating elderly population and its burden on health systems.

Recommendation 1.193

While the NMC deals with registration and control of nursing, the professional body, the Royal College of Nursing (RCN), came under notice with recommendation 1.193 "*The professional voice needs to be strengthened: The RCN should consider how better to separate its trade union and professional representative functions*". As the only body representing nursing, the RCN is both a union and a professional body. The RCN is the national voice for policy and represents nursing to the highest political levels, while at the same time, members receive union support. Once a highly visible, vocal and militant body, in recent years it has declined in both voice and (probably consequently) influence, for example, in 2006, when 20,000 nurses across England lost their jobs, there was only the tiniest comment from the RCN (Watson & Shields, 2009). Accordingly, Recommendation 1.193 requires further consideration.

Australia has many professional nursing bodies, most related to various specialities, such as the Australian College of Children and Young People's Nurses. However, these organizations never engage with industrial matters, leaving them to the Australian Nursing and Midwifery Federation (ANMF) and its related bodies in each state, for example, Queensland Nurses' Union of Employees (QNU). The ANMF and QNU have both industrial and professional objectives and work well and closely with other nursing and midwifery peak bodies to advance shared interests. The most prominent professional body which covers nursing nationally is the Australian College of Nursing, which has strong links to government and policy makers. All these organizations manage to balance both professional and industrial interests, which are not competing interests but mutually reinforcing (Queensland Nurses' Union, 2013). Importantly for Australian nurses, they need to ensure that they provide a cohesive and active voice to support both the profession and health care delivery and outcomes.

Implementation of the next part of Recommendation 1.193, that "*A forum of nursing directorsshould be formed*" seems like a good idea, but the fact that this has not already been done in the UK is yet another example of the decline of unity (and resultant power) amongst nurses in the UK at present. Similarly, "*There should be at least one nurse on the executive boardsof all healthcare organisations, including commissioners*" would increase the voice and power of nurses, and it is sad that a country, which has had nurses who were members of parliament, has, in one of its important professions, fallen so far that outside inquiries have to point out such deficiencies. It is also probably indicative of the low status of nurses in the UK, a result of low levels of education, low pay, little professional representation, and the overarching effects of the ingrained British class system (Fox, 2004).

In Australia, a forum of nursing leaders exists in some states and other salient bodies exist in others, and while not every state in Australia has health service boards, a recent initiative in Queensland ensures that a nurse sits on each of the newly instituted health service boards in that state (Office of Health Statutory Agencies, 2013).

The final point in 1.193, "*The advice of the nursing director should be obtained and recorded in relation to the impact on the quality of care and patient safety of any proposed major change in nurse staffing or facilities*" is concerning. Almost self-evident, it shows how much trouble British nursing is in if such functions have been taken away from the director of nursing.

Certainly, in Australia, it would be a brave person who tried to implement a major change in nursing staffing or facilities without the support and advice of the relevant nursing director. However, in some health districts across the country, including Queensland, the directors of both nursing and medicine positions have been rolled into one "clinical director" who is a generic manager, with no or little clinical experience (Government Careers: State, 2013). This does not augur well for health systems, or nursing, or patients. Ample rigorous evidence from Australia and overseas demonstrates that a well led nursing workforce decreases the rate of adverse events in health systems (Aiken, 2003, Trigg et al., 2013).

DISCUSSION

The Francis Report (2013) itself and its accompanying submission statements have a nightmare quality, and it is difficult to imagine that any health care service could be that bad. Another 14 NHS hospitals are under similar investigation (Donelly & Sawer, 2013); another six are reported to have higher than normal mortality rates (Keogh, 2013, Press Association, 2013), and one is led to believe that this is the tip of the iceberg. But Australia needs to take note - as C. S. Lewis (1958) said in *The Pilgrim's Regress* - "You all know," said the Guide, "that security is mortals' greatest enemy".

Taking that lesson, we in Australia cannot be complacent, nor smug.

Australia's health care system is one of the best in the world. The dichotomy between public and private health care systems means that those who can afford to pay for private care do so, and so take the load off the public system, which provides the same standard of care (sometimes better than) the private system. In this way, the excellent public system provides high quality health care to those who cannot afford to pay health insurance. At the same time, all citizens, regardless of income, can avail themselves of highly technological care, for example, transplants, and complex chemotherapy, which cannot be provided in the private system. Nonetheless, health systems are large and ungainly and errors and disasters occur. Recently, Australian media reports about poor health care have emerged.

Residents of a nursing home in New South Wales were found to have been deprived of food and subjected to inappropriate behaviour by nurses (Staff writer, 2011); a mother in Sydney birthed her baby alone after being turned away from a major hospital (News. com. au, 2013), and the scandal at Bundaberg Hospital has finally finished, with most charges against Dr Jayant Patel dropped (Smail, 2013), and a legal bill for Queensland of over $3million (NewsMail. com 2013). Unless we are open to critique and questioning, and are prepared to accept them, and learn from mistakes, poor care will occur. Australian nursing, too, must learn from the Francis (2013) recommendations.

The 'cultural cringe' in the Lucky Country

Donald Horne in 1964 said that Australia was a lucky country, blinded by its own good fortune and consequently still looking to its colonial past, and the "mother country" (England) for its inspiration. In 2013, nowhere is this more true than in health services. While the NHS collapses under the weight of its own good intentions (the aim to provide high quality, highly technological health care free to all is unsustainable), Australia, underestimating its own ability and success in health care, is employing senior people from the NHS to run health services, with stark influences on nursing.

There are many good things in the NHS, and bringing people from other countries adds richness to all. Nonetheless, Australia must wake up to the fact that its nursing profession is one of the world's leaders, and the resulting patient care, in the main, is good. Highly rigorous research from the United States and Australia into the impact of nurses – high standards of education, staffing levels, good leadership – indicates that a highly educated nursing workforce, well maintained and supported, and strongly led, reduces mortality and failure to rescue in patients in health services (Aiken et al., 2003, Twigg et al., 2012, 2013, Kutney Lee, Sloane & Aiken, 2013).

These studies, characterised by large samples and rigorous analysis, graphically demonstrate the importance to patient care of an educated, autonomous nursing workforce. The evidence they generate should be used by policy makers and managements in all health services if they want to reduce deaths and adverse events in hospitals.

Australian health systems are borrowing ideas from the NHS, such as trying to meet targets, make sure people do not spend long in hospital, and do not cost the organization much money. As staff are the most costly part of any health care budget (and by weight of numbers, nurses make up the largest proportion of any health service staffing complement), since the cutbacks of the 1990s Kennett government in Victoria, which devastated nursing numbers (Packham, 2013), it is staff cuts that are often seen as the best way to reduce costs and meet budget targets (Sweetman, 2013). Darbyshire (2013) points out that during the Mid Staffordshire disaster, before any of the staff and budget cuts were implemented, no risk assessment was done to predict the results of staff and budget cuts. It is imperative that such risk assessment be undertaken before job cuts are implemented in Australia, however, the recent cuts across Queensland's health services seem to have been undertaken with little regard to long term risk. As an example, sexual health clinics were severely affected, while large outbreaks of syphilis are occurring in some parts of the state (Stephens, 2013).

Managerialism is becoming common in healthcare, with many people with no clinical knowledge or background employed as managers under the belief that someone taught management can manage anything. Mid Staffordshire is a result of extreme managerialism, where the clinical aspects of care were ignored because everyone was concerned with management outcomes, rather than patient outcomes. Francis (2013) reported that everyone in the organization looked upward to the manager above them, rather than looking outward to the patients and their families. Everyone, from the trust executives and board to the nurses giving care, lost sight of their fundamental responsibilities, that is, to give the best patient care possible, ignoring that fact that patient outcomes are much more important than financial ones. However, it is not possible to have an infinite health budget. Cost, these days, is an ethical issue (Godlee, 2011) and the burgeoning cost of health care is one of the reasons why the NHS is collapsing at present. It behoves all to ensure the health dollar is spent wisely, but wisdom excludes making the business the focus rather than patient care. Private health systems, with their business models, are well aware of this. While they need to make a profit, they know that market forces will dictate patients' use of their service, and any suggestion that their patient care is compromised by the need to make money will result in consumers (patients) not using their service.

Some discussing nursing's extreme failures in Mid Staffordshire use the cliché of university education creating all the ills. While this is a seductive argument for some (Marrin, 2009, Dalrymple, 2009) it ignores facts about the standard of nursing education on offer in the UK, and also overlooks the status of nursing. All nursing education in Scotland and Wales is at degree level, so these remarks pertain to England. I have written extensively (Shields & Watson, 2007, 2008, Watson & Shields, 2009) on the low admission criteria for nursing courses there (five GCSE – Grade 10 - passes – no standard of pass required) and the low level of qualification – less than 10% of nurses in England held Bachelor degrees (Sastry, 2005) and so it is not surprising that poor care was endemic. In 2010 the Nursing and Midwifery Council stated that by 2013, all nurses would require a degree for registration (Watson & Shields, 2009). Whether or not this has occurred is difficult to ascertain, but given the policy speeches of David Cameron before his election in 2010, (Santry, 2010), where he denigrated the idea, it is possible that this may not be as high on the agenda as it once was.

As to the status of nurses, given the low standards of education when compared with other disciplines (Shields & Watson, 2007), low rates of pay (Watson & Shields, 2009), and lack of professional support from their main nursing body, the RCN (Watson & Shields, 2009, Francis, 2013), it is not surprising that nursing is not as highly regarded as other professions, resulting in lack of autonomy, deference to other health professions, and little value placed on the profession by the public. Australian nurses are privileged to hold a high status due to their high levels of education. As an example, at Townsville Hospital in Queensland, six registered nurses on staff are doctorally prepared and one holds a higher doctorate. It is imperative that Australian nursing maintains these standards, as education levels are positively correlated with good nursing care and safe patient outcomes (Aiken et al., 2003 Twigg et al., 2013).

Fuelling much of the debate resulting from the Francis Report is the growing nursing shortage besetting many countries. In the UK, nursing roles are being taken over by HCAs – unqualified workers who have no line management to registered nurses. A solution would be to ensure all unqualified workers were employed as Assistants-in-Nursing, who answer directly to the registered nurse, so some control can be held over the work of such workers.

On Australia Day 2010, the then Prime Minister, Kevin Rudd, said "as we enter this second decade of the 21st century, Australians can be optimistic about our future, but we cannot afford to mistake optimism for complacency" (Rudd, 2010). Such is true for Australian nursing, as we face the same problems, albeit with a time lag, of our British colleagues. Funding pressures are also increasing in our health system, from the escalating costs of drugs, procedures, technology and health management (Duckett, 2013). In the meantime, patients and clients are becoming health literate as their use of the Internet expands, and, as in the UK, they expect the best in the way of treatment, and their nursing care.

Australian nurses cannot afford to become complacent, and we must be prepared to stand up for the rights of our patients/clients, and for the profession itself. This requires a deal of courage, especially if one's employment is threatened by speaking out. Industrial and professional bodies are the best advocates of collective voice and so nurses must be prepared to engage with them. As Edmund Burke (1729-1797) (date unknown) said "All that is necessary for the triumph of evil is that good men do nothing".

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27 February 2014

Acknowledgements

This paper was presented as the keynote address at the 32nd Annual Conference, Queensland Nurses' Union of Employees. Brisbane, 7-9 August 2013. I thank Ms Beth Mohle from Queensland Nurses' Union of Employees, for advice about unions, and Ms Kay Newman, for help with editing.

References

To be added.