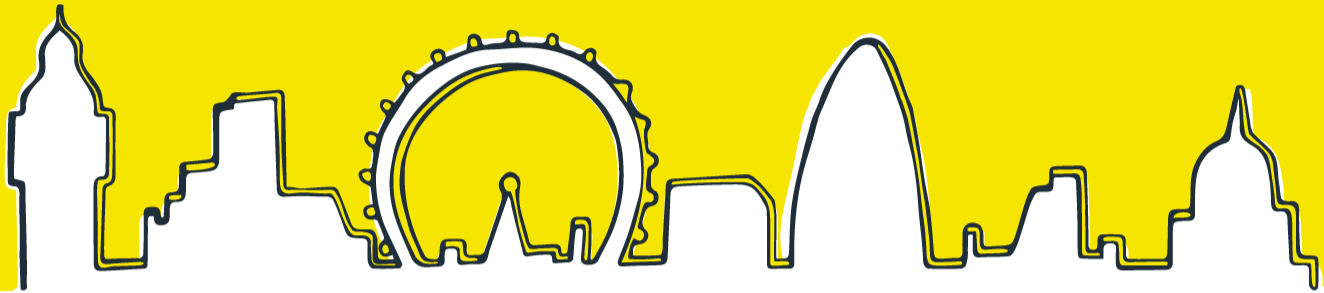
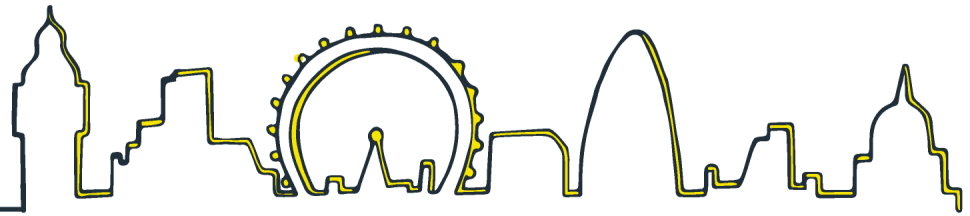


CapitalNurse Expo
22 Mar 2018
Masterclass Slides

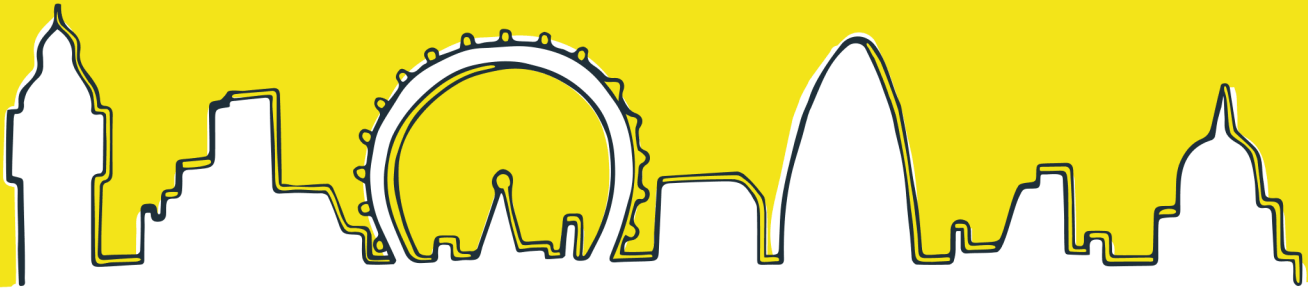
CapitalNurse is jointly sponsored by Health Education England, NHS England and NHS Improvement

Contents



CAPITAL nurse

1. What has CapitalNurse learned about London's nursing workforce - and why the data matters'



CAPITAL nurse

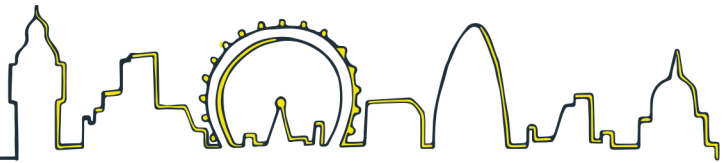
What has CapitalNurse learned about London's nursing workforce - and why the data matters

Masterclass presentation for CapitalNurse Expo 22 March 2018

CapitalNurse is jointly sponsored by Health Education England, NHS England and NHS Improvement

The university journey for nursing

Branch	Qualifiation	Starters	2016-17 Output	Retention Rate
Adult	BSc	1507	1315	87%
Adult	PG Dip/MSc	258	215	83%
Child	BSc	572	464	81%
Child	PG Dip/MSc	91	75	82%
Mental Health	BSc	374	330	88%
Mental Health	PG Dip/MSc	187	154	82%
Learning Disabilities	BSc	75	57	76%

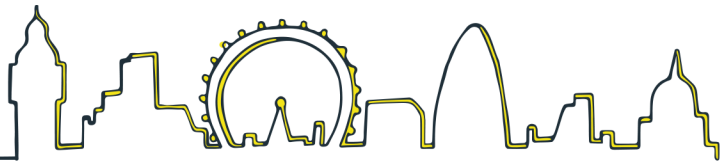


The university journey for nursing

Steady improvement over several years

A range of initiatives, including:

- Early identification and intervention of strugglers
- Improved support systems
- Effective academic work feedback
- Well supported clinical placements
- Collaborative working and sharing best practice



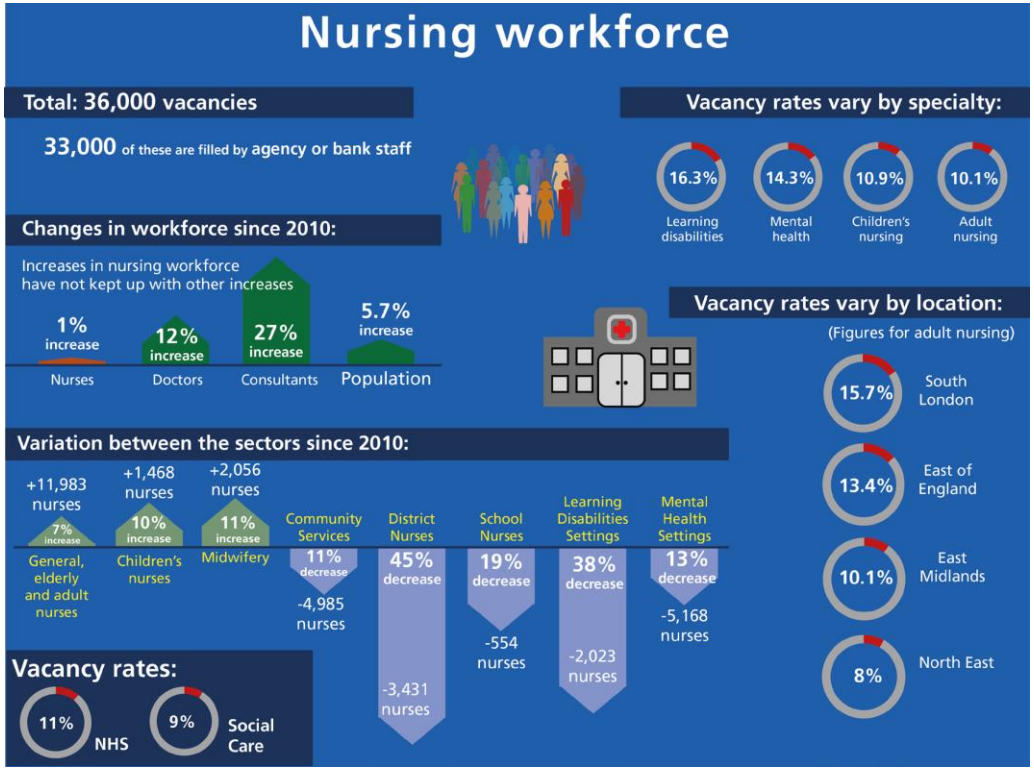
Using data to inform workforce planning to have the right nursing workforce with the right skills in the right place at the right time

- Changes in Health Education Funding –HEE no longer having a commissioning role
- New ways to train to achieve NMC registration
- Apprenticeship Levy
- Preceptorship Pathways
- Post preceptorship career development pathways

The life of a London nurse – burden of commuting time

- Average commute for London's nurses - 13.56 miles each way, 27 mile round trip
- On top of a 12 hour shift nurses travel approx two hours a day
- Nurses live 2.25 miles further from their workplace in 2018 than 2008 - nearly 25% or extra Oyster zone
- Most nurses live within a 15 - 20 mile radius of their workplace but range two -100+ miles

(Source - Royal College of Nursing, March 2018)


Nursing workforce
Total: 36,000 vacancies
33,000 of these are filled by agency or bank staff
Changes in workforce since 2010:
Increases in nursing workforce have not kept up with other increases
1% increase
Nurses
12% increase
Doctors
27% increase
Consultants
5.7% increase
Population
Vacancy rates vary by specialty:
16.3% Learning disabilities
14.3% Mental health
10.9% Children's nursing
10.1% Adult nursing
Vacancy rates vary by location:
(Figures for adult nursing)
15.7% South London
13.4% East of England
10.1% East Midlands
8% North East
Variation between the sectors since 2010:
+11,983 nurses
7% increase
General, elderly and adult nurses
+1,468 nurses
10% increase
Children's nurses
+2,056 nurses
11% increase
Midwifery
Community Services
11% decrease
-4,985 nurses
District Nurses
45% decrease
-3,431 nurses
School Nurses
19% decrease
-554 nurses
Learning Disabilities Settings
38% decrease
-2,023 nurses
Mental Health Settings
13% decrease
-5,168 nurses
Vacancy rates:
11% NHS
9% Social Care

Why do nurses leave the profession, other than retirement?

- **Working conditions** (eg. staffing levels, workload) — **44%**
- A change in personal circumstances (eg. ill-health, child care responsibilities) — **28%**
- Disillusionment with the quality of care provided to patients — **27%**
- Concerns about being able to meet revalidation requirements — **26%**
- Leaving the UK — **18%**
- Poor pay and benefits — **16%**

Source: The NMC survey of people who had left the register between June 2016 and May 2017.
Total number of respondent: **4,544**
Of these, **2,240 did not cite retirement as a reason for leaving.**
For this group, these are **the top reasons for leaving.**

Nurses who left the profession but then decided to return:

Top reason for initially leaving:

Lack of flexibility

Other reasons:

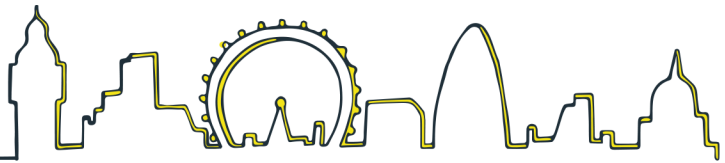
- Ongoing education and training opportunities
- Pay
- Pressure of work

Source: Health Education England – oral evidence

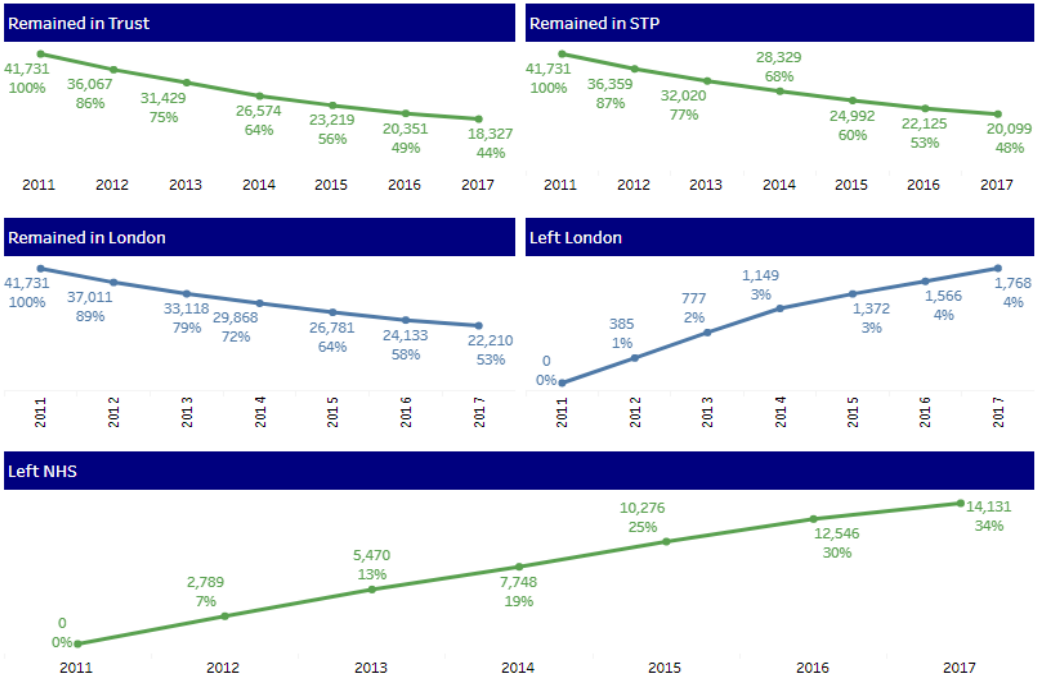
The nursing workforce in London

- 173,757 WTE staff across 36 trusts
- Average nurse vacancy is 13% (national 9%)
- Average nurse turnover 15%
- Nearly 20% of newly qualified nurses in the capital leave within their first year
- Practice nurse ages indicate a retirement bulge over next ten years.

'Baby Boomers'	'Generation X'	'Generation Y'	'Generation Z'
1946-1964	1965-1980	1981-1994	1995-2010
Motivated and hard working; define self-worth by work and accomplishments.	Practical self-starters, but work-life balance important.	Ambitious, with high career expectations; need mentorship and reassurance.	Highly innovative, but will expect to be informed. Personal freedom is essential.
25% of the NHS workforce	40% of the NHS workforce	35% of the NHS workforce	<5% of the NHS workforce

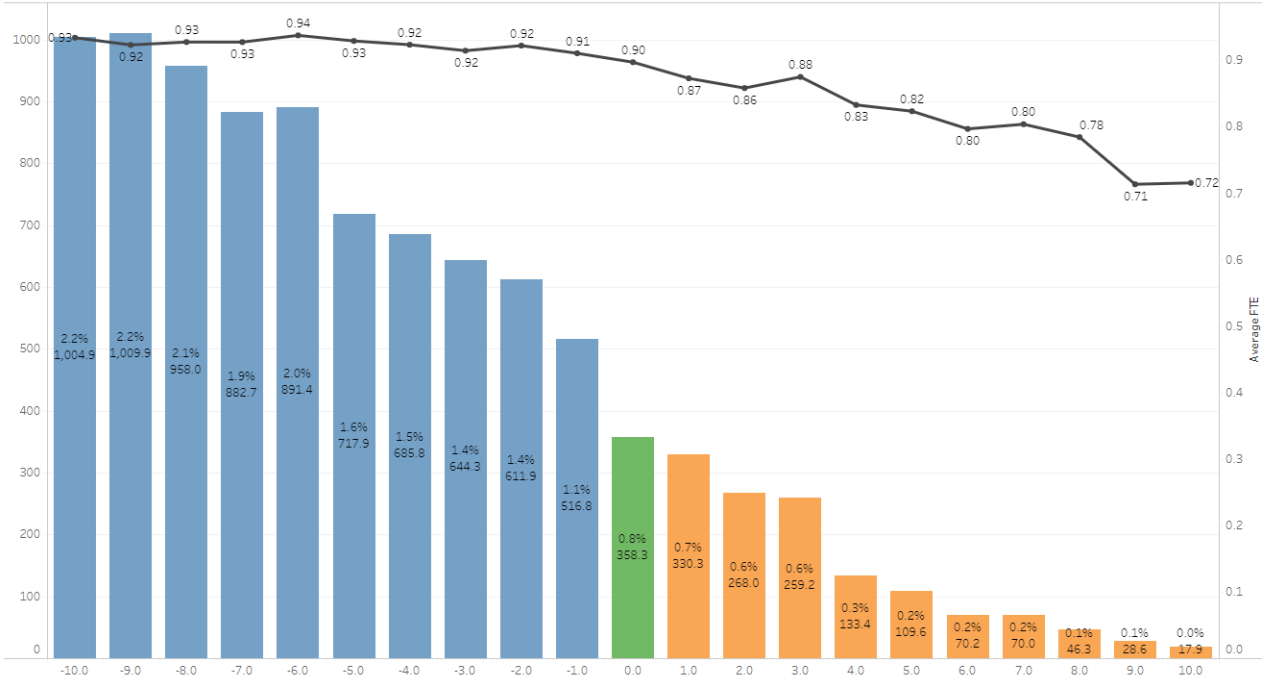


London nursing retention



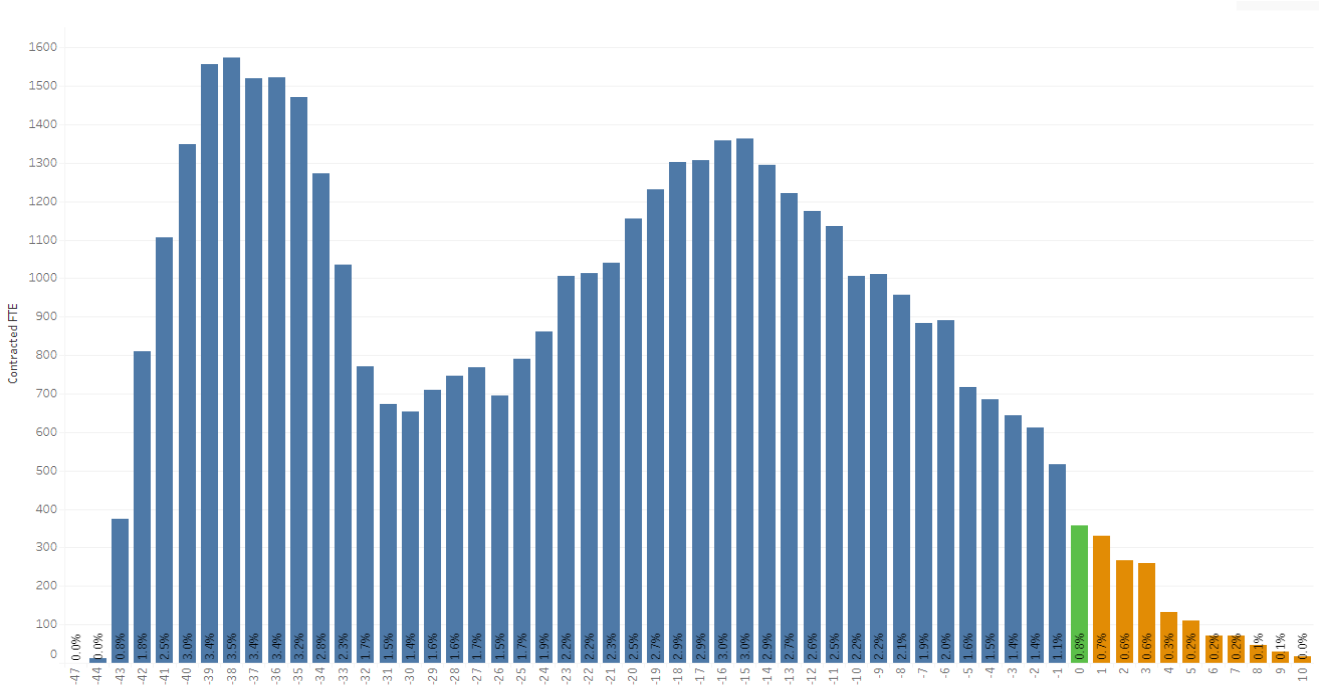
- London nurse retention is worsening.
- Churn around London is less than churn out of NHS.

Everyone is going to retire … or are they?



- Nurses are working past the pensionable age.
- How will future pension changes impact this?
- How will the ever increasing cost of living in London impact this?

Everyone is going to retire … or are they?



- Is intervention 5/10 years pre retirement too late?
- Mid career low retention risks future skills gap, inexperience and leaders of the future.
- NQ low retention risks sufficient future supply.

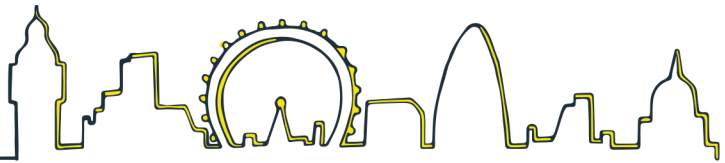
London NQ retention

The table shows the retention proportions of newly qualified nurses from cohorts between 2011-2015.

For this analysis the nurses in the cohorts are filtered by the following requirements:

- Nurses who started within the last 12 months in a post on the bottom of the agenda for change band 5 pay scale; and
- The source of recruitment is coded by their employer as education. This includes education/training, education sector, newly registered- first, newly registered – further and return to practice.
- Snap shots were taken on December the 31 each year.

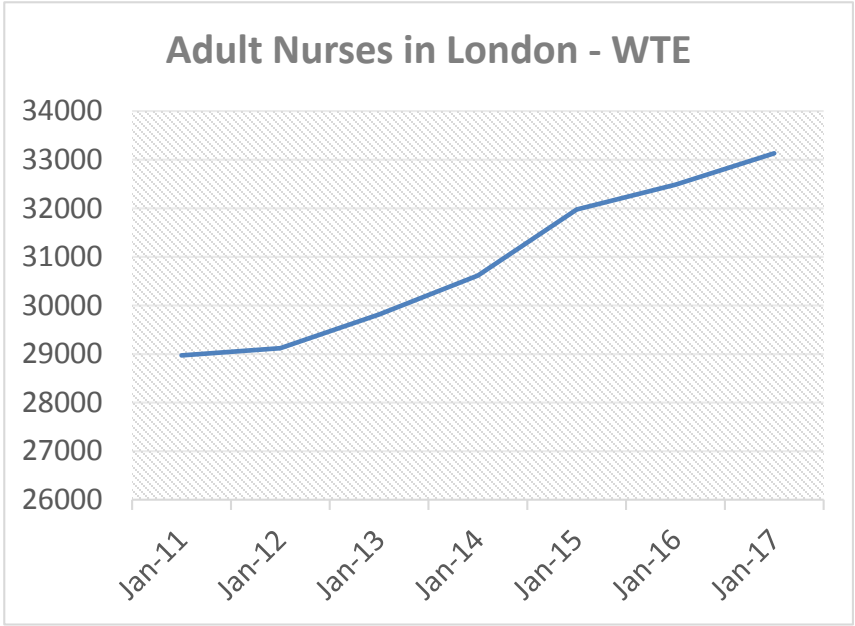
	Entry Year				
	2011	2012	2013	2014	2015
After 1 year	86%	85%	85%	85%	81%
After 2 years	71%	75%	73%	70%	
After 3 years	63%	67%	65%		
After 4 years	60%	61%			
After 5 years	56%				



Current position: Nursing shortage

- Adult nurses in London increased by 13.8% over 5 years compared to 7% nationally
- Demand for nursing outstripping supply
- Nursing on shortage occupation list
- Vacancy rates differ between nursing specialties and geography
- ‘Nursing workforce needs to be expanded at scale and pace’

House of Commons Health Committee, The nursing workforce, Second Report of Session 2017–19



The impact of Brexit

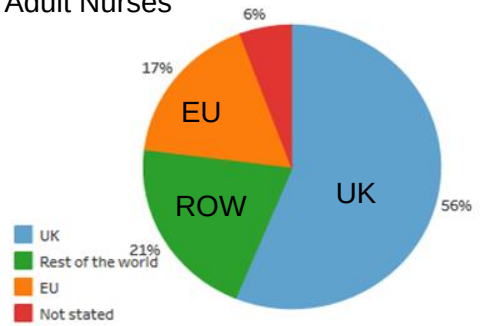
The core facts….

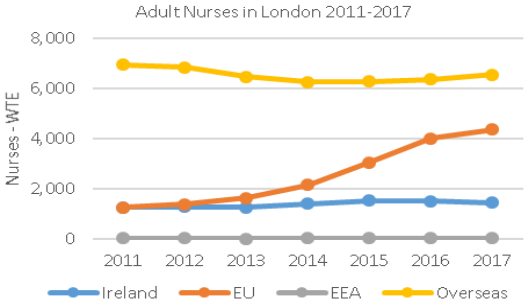
- The EU workforce is highly valued
- London's NHS has a larger EU workforce compared to England
- Rapid growth of EU Nursing workforce since 2014 has slowed down since 2016
- Younger and more junior profile of EU Nurses

Planning for the impact of Brexit should be part of a comprehensive workforce strategy

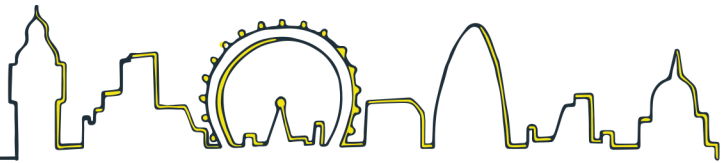
Monitoring trends regularly and scenario planning will be key.

Adult Nurses





(Source: ESR Aug 2017)

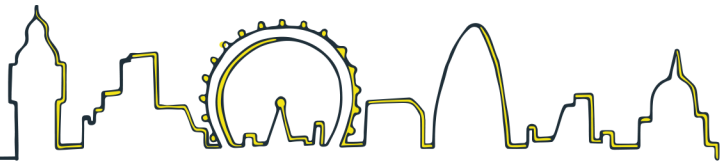


Future workforce supply

Key issues to monitor:

- Significant reduction in EU Nurses joining NMC register since 2016 has been linked to new International English Language Test (IELT) and Brexit

- Introduction of tuition fees for undergraduate Nursing students affecting application rates and profile of new supply:
  - Application rates fell by 18% in 2017 **but** uptake to courses was maintained.
  - Decline of applicants and acceptances within older age groups



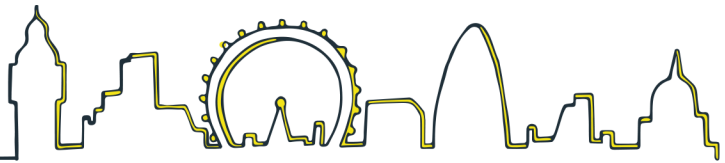
Next steps

How can we best prepare for the impact of Brexit

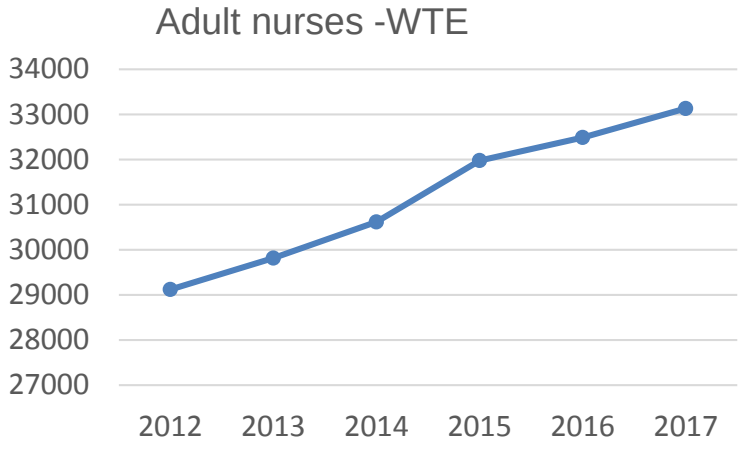
Mitigating strategies could be developed by:

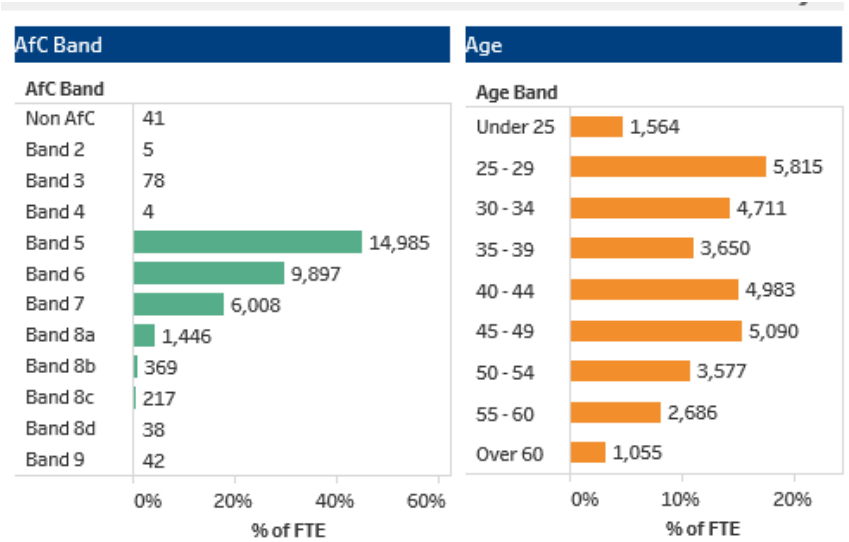
- Strategic workforce planning and monitoring trends in workforce and student supply
- Detailed intelligence by professions and sectors (health and social care)
- Scenario modelling for staff shortages and the impact of immigration policy
- Assessment of how best to utilise and manage international recruitment and retention

- **Further engagement with nurses will be necessary to effectively undertake scenario modelling and workforce planning**



Adult nursing





Vacancy and turnover rates

- Average nurse vacancy rates approximately 13%, compared to national averages of 9%.
- Average turnover rate of 15% across all nursing professions, 14% to 20% for adult nursing

Session discussion

Main points shared

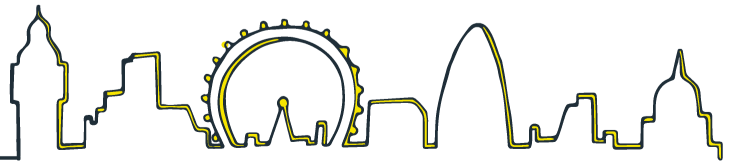
- Retention is improving, know what universities are doing, but what is happening more widely?
- New role/ training – how to use data to inform decisions and use to our advantage
- Maintain new wave of nurses - concentrate on this group
- Collaborative working and sharing best practice

Main points discussed

- Flexibility in working patterns/times
- Establishment that reflects different roles and work of these roles
- Opportunity gaps: gender, ethnicity
- Travel costs – emergency response value should be recognised, like police, CapitalNurse Oyster
- International recruitment

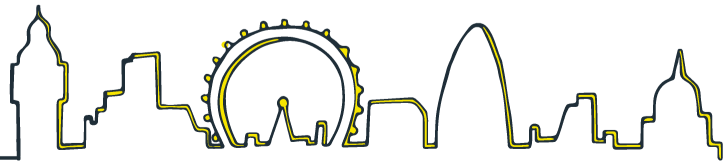
Next steps/how can CapitalNurse help?

- Society/social issues: supporting women (career breaks), shared parental leave, job sharing, housing, transport
- Research into colleges and attitudes prior to entering/considering a nursing career
- BME and gender promotion/opportunity differences
- International markets – IELTS



For queries please contact:

capitalnurse@hee.nhs.uk



CAPITAL nurse

2. Workforce Race Equality Standard (WRES): a view from nursing and midwifery

Workforce Race Equality in the NHS

Yvonne Coghill, Habib Naqvi,
and Owen Chinembiri,
NHS England

March 2018

WRES video

https://youtu.be/_sPrEGG68Go

The NHS Constitution

The NHS belongs to the people.

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.

Ethnic inequalities: a global overview

- There is strong evidence globally that people from BME backgrounds that live in white majority countries e.g. the US, UK, Australia and New Zealand have poorer life chances and experiences compared to their white counterparts:
- *Health – more likely to get chronic diseases and die sooner*
- *Wealth – make less money over their life course*
- *Employment – less likely to be promoted*
- *Housing – live in poorer areas and dwellings*
- *Judiciary – more likely to be imprisoned*
  - Race Disparity Audit

Black and Minority Ethnic (BME) staff in the NHS

- 1.4 million people work in the NHS
- 20% staff from BME backgrounds
- 28% GPs from BME backgrounds
- 40% of Hospital Doctors are from BME backgrounds
- 20% Nurses and Midwives (qualified and unqualified) Rising to 50% in London

But…

- 3 BME CEOs (from ~235)
- 2 Exec & 4 Director of Nursing (from ~450k nurses)
- Less than 3% Medical Directors
- Less than 5% senior managers from BME backgrounds

Where are the BME role models?

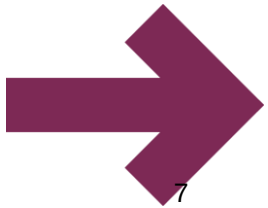
FOR HEALTHCARE LEADERS HSJ 100

The *HSJ 100* list for 2017 showed **no** change in diversity across the senior healthcare leadership in England – still just four BME in the top 100 list.

Sir Robert Francis QC, *Freedom to speak up - a report into whistleblowing in the NHS*

- More BME staff are unsatisfied with the outcome of workplace investigations than white staff (40%:27%)
- BME staff are more likely to be victimised by management than white staff (21%:12.5%)
- BME staff are less likely to be praised by management after raising a concern than white staff (3%:7.2%)
- BME staff are more likely than white staff to not raise a concern for fear of victimisation (24%:13%)

Impact on patient care…!

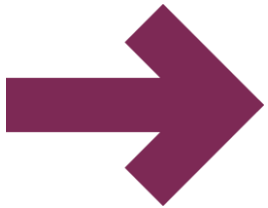


The consequences for people

- Disillusionment
- Unhappiness
- Depression
- Lack of confidence
- Anger/Rage
- Lack of belief in the system
- Lack of engagement and buy in
- Resentment
- POOR PERFORMANCE

The reasons for tackling workforce race inequality in the NHS

- **THE QUALITY CASE** – it ensures high quality care, patient satisfaction and patient safety
- **THE FINANCIAL CASE** – it makes good business sense
- **THE MORAL CASE** – it's the right thing to do
- **THE LEGAL CASE** – the law says that we should



NHS Workforce Race Equality Standard

The Workforce Race Equality Standard is a set of indicators that, for the first time, require all organisations with NHS contracts, to demonstrate progress against a number of areas of race equality, including a specific indicator to address the low levels of BME Board representation.

WRES phase two

Enabling sustainable accountability – improving patient care for all

NHS England

Aim: Closing the gaps in workforce race equality across the NHS

Cross cutting themes:
Leadership & accountability, engagement, cultural change, outcomes, sustainability

Enabling People

- Meaningful engagement
- Understanding narrative
- Focused improvement
- Resource and support

Embedding Accountability

- System alignment
- Regulation and scrutiny
- New healthcare architecture

Evidencing Outcomes

- Data and intelligence
- Replicable good practice
- Evaluation and sustainability

NHS Constitution values

The 9 WRES indicators

NHS England

Indicator 1	Indicator 2	Indicator 3	Indicator 4
•Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM compared with the percentage of staff in the overall workforce	•Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts	•Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process	•Relative likelihood of BME staff accessing non mandatory training and CPD as compared to white staff

Indicator 5	Indicator 6	Indicator 7	Indicator 8	Indicator 9
•KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	•KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	•KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	•Q17. Percentage of staff experiencing harassment, bullying or abuse from manager/team leader or colleague	•Percentage difference between the organisations' Board membership and its overall workforce

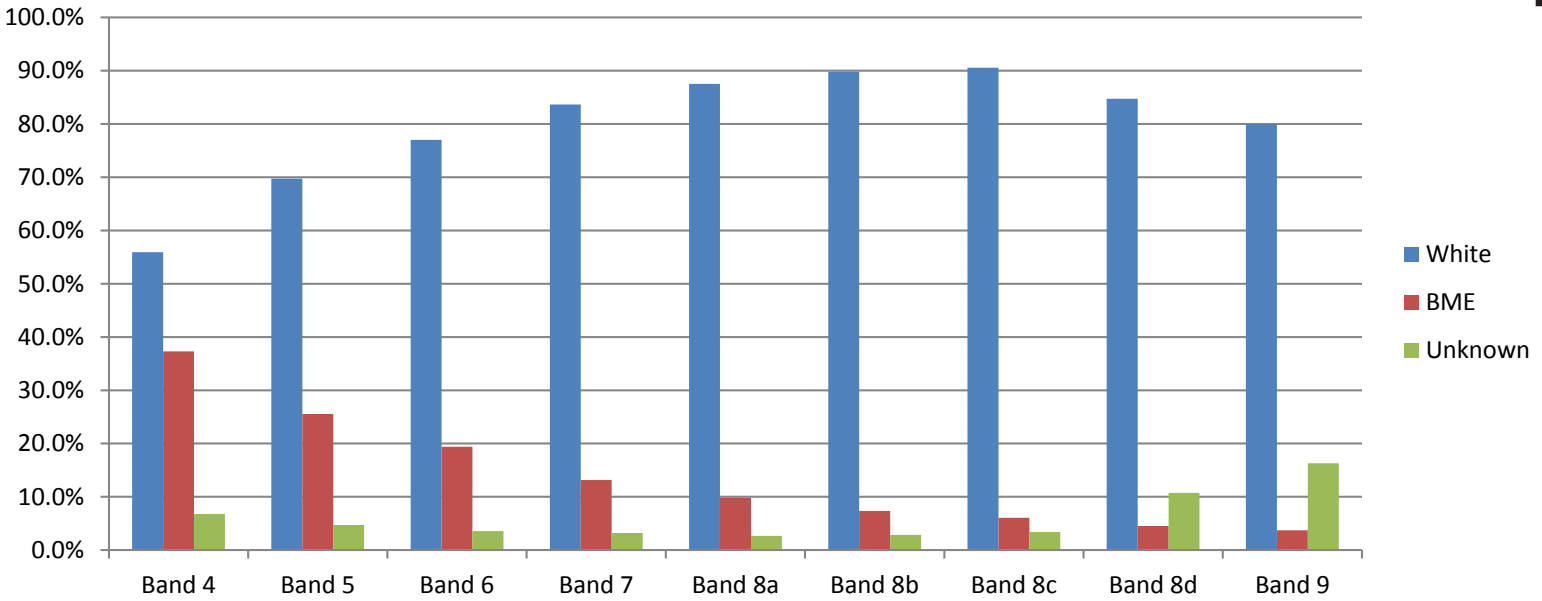
Indicator 1

BME representation

NHS England

Ethnicity of Nursing staff by AfC bands – July 2017

(Data source - National ESR)

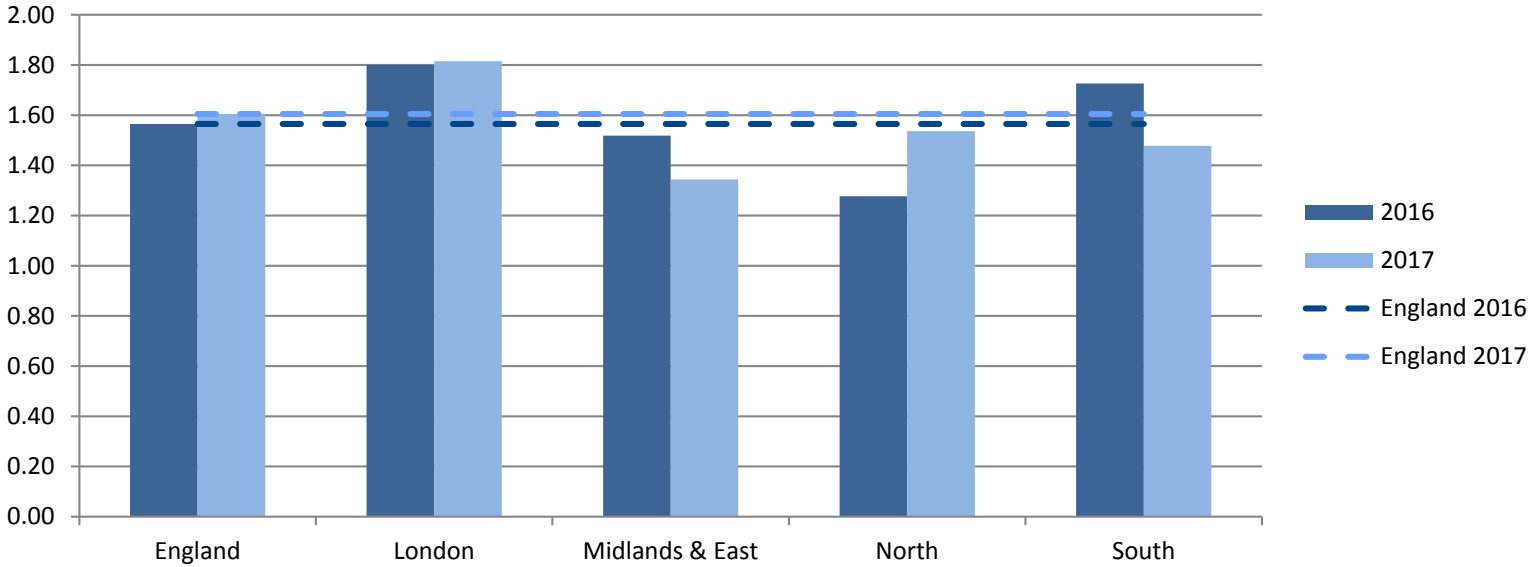


- 20.8% of all Nurses and Health Visitors are from a BME background.
- BME staff are overrepresented in AFC Bands 4 and 5, and underrepresented in all other bands.

Indicator 2

Relative likelihood of White staff being appointed from shortlisting compared to BME staff

Relative likelihood of white staff being appointed from shortlisting compared to BME staff by region – 2016 & 2017



- Here in London, white staff are 1.8 times relatively more likely to be appointed from shortlisting compared to BME staff .

Indicator 5 - 8

2017 NHS Staff Survey Results

NHS England

WRES Indicators 5 - 8.

WRES Indicator	Staff Survey Question text	White staff	BME staff
5	% experiencing harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public in last 12 months	27.5%	28.5%
6	% experiencing harassment, bullying or abuse at work from managers in last 12 months.	12.2%	14.6%
	% experiencing harassment, bullying or abuse at work from other colleagues in last 12 months.	16.8%	22.0%
7	% saying the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	86.6%	71.6%
8	% saying they had experienced discrimination from their manager / team leader or other colleagues in the last 12 months	6.6%	15.0%

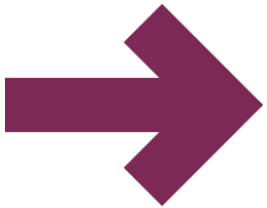
For all four WRES indicators BME staff report a worse experience compared to white staff.

Exercise 1:
Open discussion: WRES data

Opportunity to ask questions, discuss issues and themes emerging from the WRES data presented.

Ten steps:
Good WRES implementation

1. Has the organisation completed and published its annual WRES data return
2. Have BME staff and local social partnership body been involved in discussions regarding the data
3. Is a robust action plan produced and published - reflecting the what the data show
4. Have meaningful discussions taken place on proposed actions in relation to key emerging issues
5. Is there a board member responsible for the WRES (and equality)



Ten steps:
Good WRES implementation

6. Is there a BME staff group or network – are there formal arrangements to meet organisations HR team regularly
7. How robust and complete is workforce ethnicity monitoring
8. What steps is the organisation taking to ensure BME are supported to complete the NHS staff survey – is there a full staff census
9. To what extent is workforce race equality, and equality in general, embedded and mainstreamed within the organisation
10. Does the organisation link with other peer organisations to share learning and replicable good practice

Exercise 2:
Your WRES pledge

- There are only 7.4 fantastic people in the WRES team, and we can't work with over 500 NHS organisations at the same time.
- We need your help. You have the power to make a difference.
- From the 10 steps Habib/Yvonne have gone through, what one practical action are you personally going to take back to your organisation?
  - 5 minutes to think and discuss with persons next to you, and 30 seconds per person to share.
  - When feeding back, please say – who you are, role/organisation, and the action you will take.
  - If you are on Twitter, please tweet your action using the hashtag #WRES and copy in @wres_team

Resources and further information

WEB:

www.england.nhs.uk/wres/

EMAIL:

england.wres@nhs.net

TWITTER (#WRES):

@wres_team

Session discussion

Main points shared

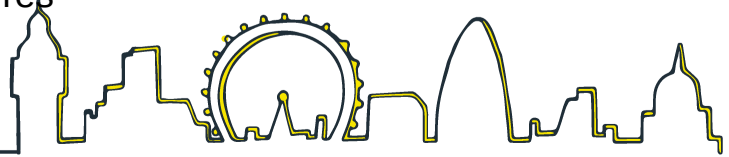
- 1 in 5 in NHS from BME groups, yet only 3 Chief Execs in NHS are
- 10% of population own 90% of wealth/power
- Presented development and roll out of WRES across NHS
- Presentation of data and 9 WRES indicators

Main points discussed

- Seems to be little change on employment stats, why hasn't change been fast enough
- Importance of #WRES data to inform change
- To what extent are organisations being held to account for not delivering on WRES – should celebrate those organisations that are doing well and show links to improving care
- What can be done practically to change the culture: sharing best practice; look at how nurturing talent; mentoring practices

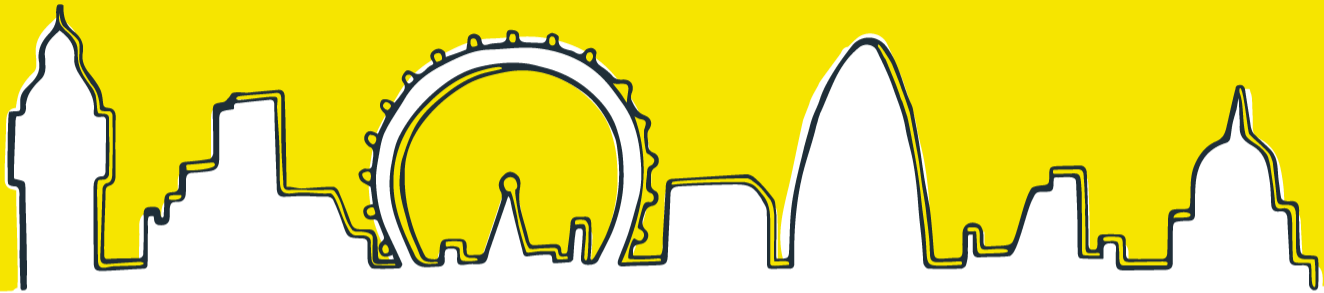
Next steps/how can CapitalNurse help?

- Creation of BME networks to help share stories to change cultures
- #WRES
- London wide strategy developed



CAPITAL nurse

3. An hour in the company of Flo and Jo: Working with the generations to create attractive nursing roles



An hour in the company of Flo and Jo:

Working with the generations to create attractive nursing roles

Mark Cole, London Leadership Academy
Chris Caldwell, Capital Nurse

CapitalNurse is jointly sponsored by Health Education England, NHS England and NHS Improvement

Session discussion

Main points shared

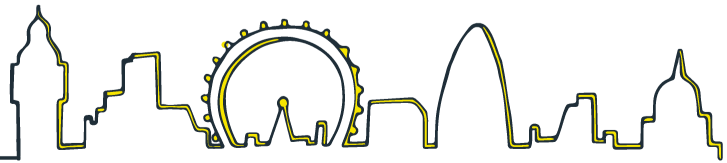
- Need to have jobs/roles that make nurses want to stay
- Flexibility
- No one option suites everybody
- Valuing experience – what we have to offer

Main points discussed

- Needs to be flexibility with the systems to enable working, e.g. self-rostering
- Platform to have conversations/understand the asks, don't make assumptions – career conversations, individualised approach, career guidance for all
- Valuing experience – what can they do in a team that others can't

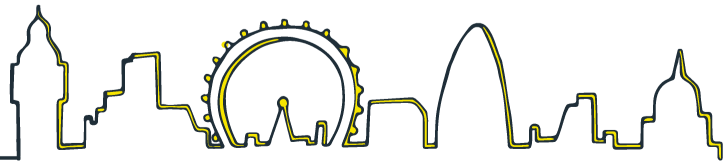
Next steps/how can CapitalNurse help?

- Teaching at all levels on the enabling flexibility – from CFO to ward managers writing the rotas
- Development of career conversations for all



For queries please contact:

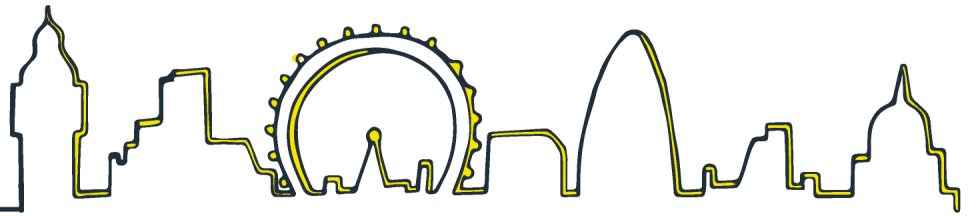
chris.caldwell@hee.nhs.uk



CAPITAL nurse

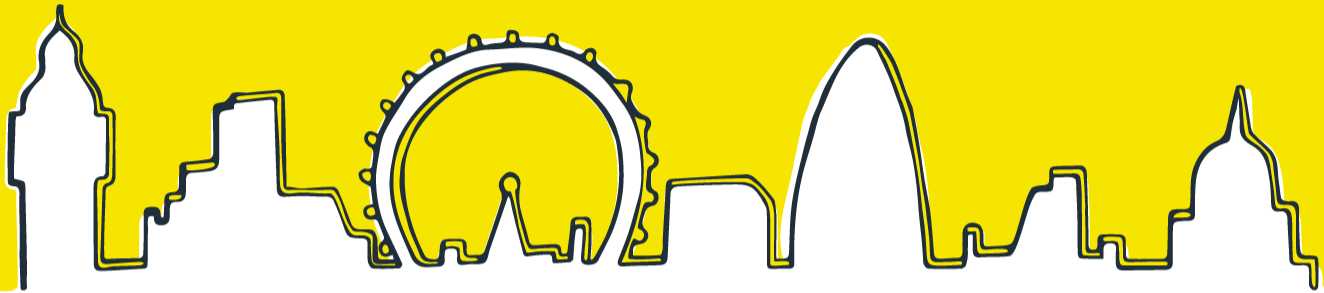
4. Exploring the views of London student nurses and newly qualified nurses about the recruitment process: What can we learn about what matters to them?

Slides being finalised – will be uploaded shortly



CAPITAL nurse

5. Leading Collaborative Change - how can we do it?



CAPITAL nurse

Leading Collaborative Change

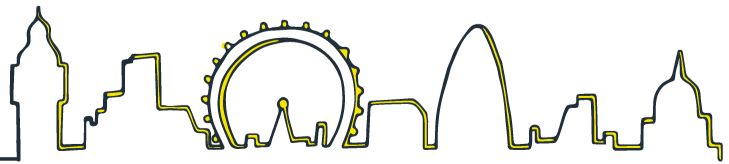
Natalie Holbery, Clinical Lead

CapitalNurse is jointly sponsored by Health Education England, NHS England and NHS Improvement

Intended learning outcomes

By the end of this session you should be able to:

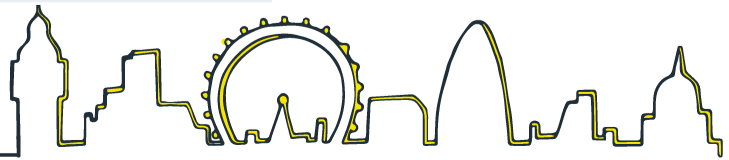
- Understand the process of leading collaborative change
- Understand the key factors required for 'good' collaborative change
- Identify key stakeholders and roles for successful collaborative change
- Apply examples from your practice



Reflections...

Think of a change you have been involved with.

Consider the following;
How were you invovled?
Who else was involved?
Describe the process
How did it feel?
Was it successful?
What were the measures of success?

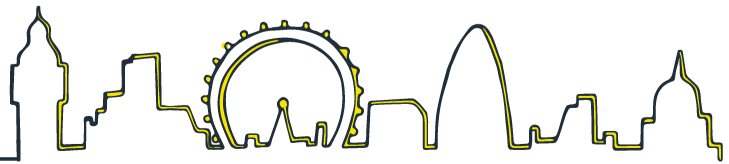


Collaboration

1. The action of working with someone to produce something

2. Traitorous cooperation with an enemy

Oxford English Dictionary



Collaborative change

- Collaborative change - more than just change manangement

Change management	Collaborative chagne
Outcome driven	Process driven
Goals often driven by external influence	Goals determined by stakeholders
Co-operation	Co-production

- Requires a focus on both the product (cooperation) and process (collaboration)

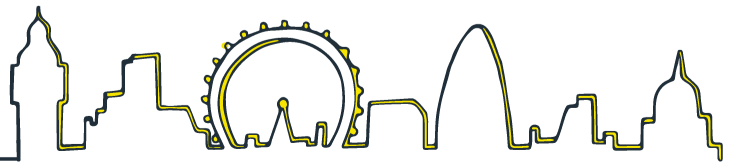
Collaborative change - a systems approach

- Change in health care is usually complex
- A systems approach considers two important foundations;

1. No single thing can change without influencing every part of the system to which it belongs

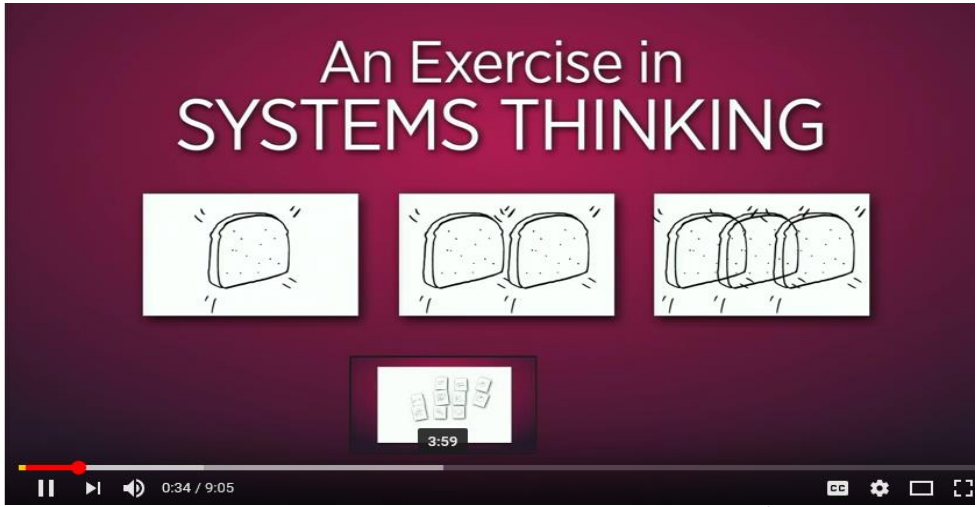
2. Change in any single part of a system impacts every other part

(Mitch Javidi 2003)



Understanding all parts of the system

https://www.youtube.com/watch?v=_vS_b7cJn2A

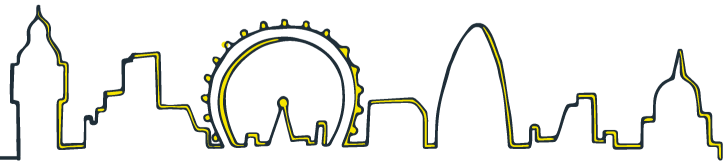


The 'how to' of collaborative change

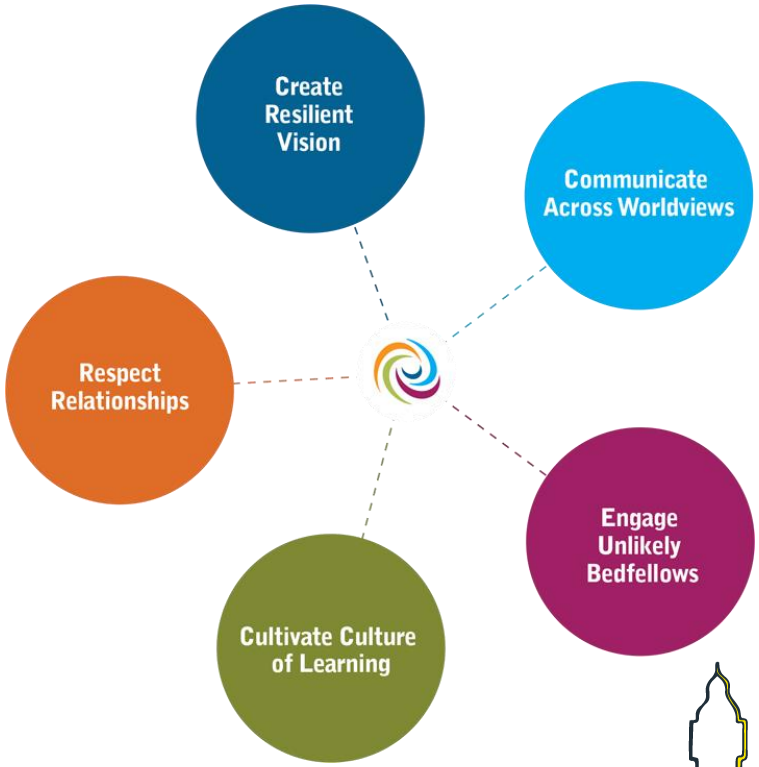
Five tenets of collaborative change

Understanding the change problem

Involving people



Five tenets of collaborative change

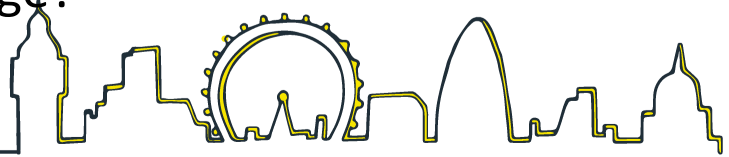


Understanding the change problem

The classic who, what, where, when, why and how....

“Who” questions:

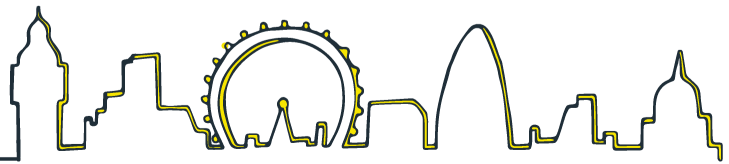
- Who from the organisation needs to be involved in the change?
- Who is likely to be affected most by the change?
- Who is likely to try to obstruct the change?
- Who has the most invested in the status quo?
- Who are the most likely champions of change?



Understanding the change problem

“What” questions:

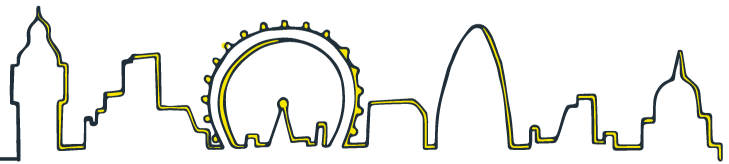
- What practice/s need to be changed?
- What must be communicated to stakeholders?
- What behaviors do we need to change?
- What resources will we need?
- What are we trying to achieve?



Understanding the change problem

“Where” questions:

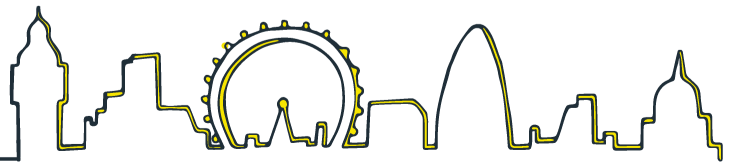
- Where are changes most needed?
- Where do we have support for the changes?
- Where do the senior managers/leaders stand with regard to the need for change?
- Where will the funding come from to implement the changes?



Understanding the change problem

“When” questions:

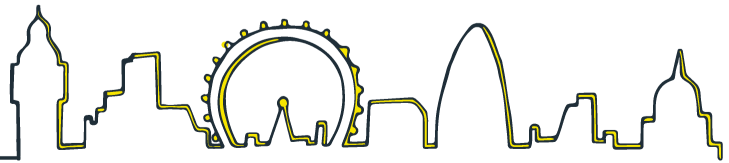
- When should we implement the change?
- When will senior managers/leaders consider implementation?
- When should we communicate to the stakeholders?
- When should we evaluate the impact of the change?



Understanding the change problem

“Why” questions:

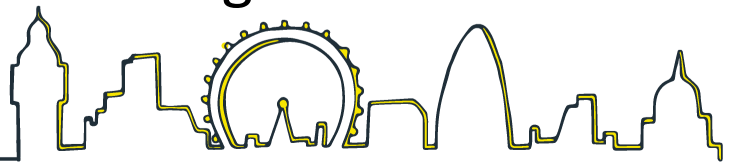
- Why do we need to change our practices?
- Why do we need to communicate new services/models/approaches to our stakeholders?



Understanding the change problem

“How” questions:

- How do we change our practices for better?
- How do we change the way we treat and communicate with our stakeholders?
- How should we communicate the organisation’s vision to other stakeholders?
- How will we measure the impact of the change?

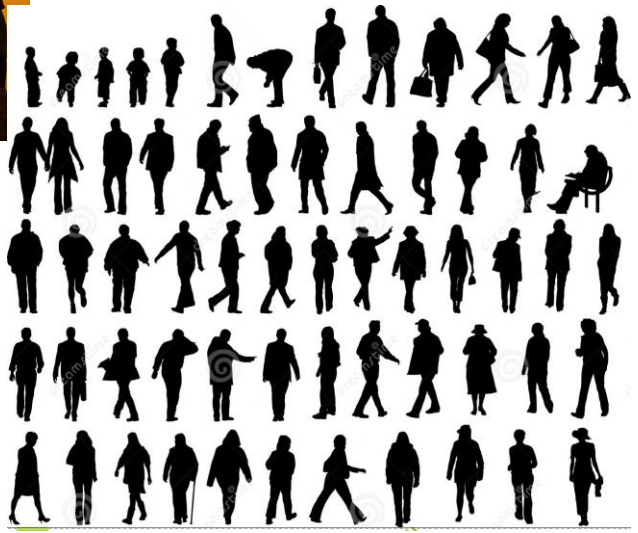


Who needs to be involved?

Agents

Champions

Targets

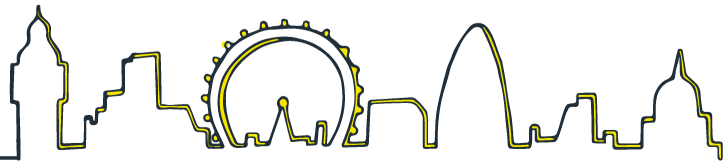


Sponsors

Reflections

Returning to your change example:

Discuss the following;
Did it feel collaborative?
Was a systems approach taken?
Can you identify the 5 tenets in your change?
Can you identify the key roles as discussed (champions, agents, sponsors, targets)
What were the challenges?

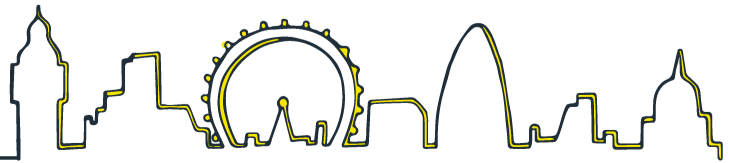


Challenges of collaborative change

- Disengagement
- Agreeing the outcome
- Agreeing the process
- 'Letting go'
- Conflicting drivers
- Funding

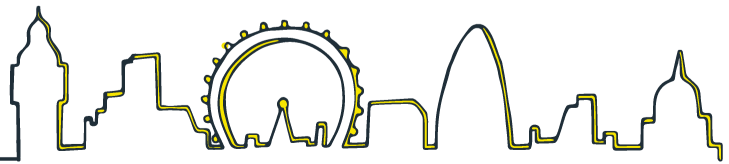
Challenges of collaborative change

- How do you deal with people who don't like to or want to collaborate?
- How do you agree the outcome & process?
- How does it feel to 'let go'?



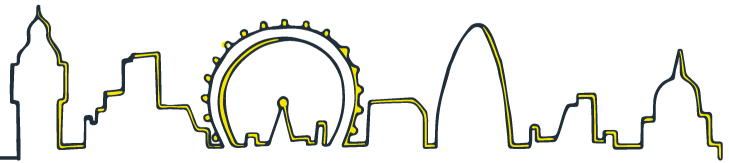
Steps to address the challenges

- Recognise strengths and weaknesses in individuals, teams & systems
- Be honest
- Be involved
- Seek all stakeholder perspectives



Steps to address the challenges

- Anticipate unintended consequences, where possible
- Understand driving & restraining forces
- Change the ways things are done, not the way people think
- Consider personality type indicators - yourself, team members

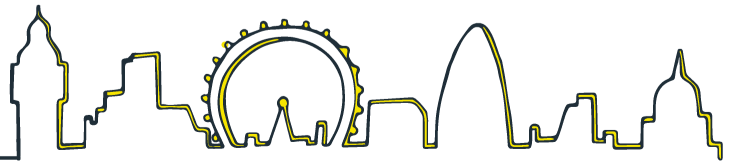


Example of collaborative change

Urgent & emergency care qualification in specialism (QIS)

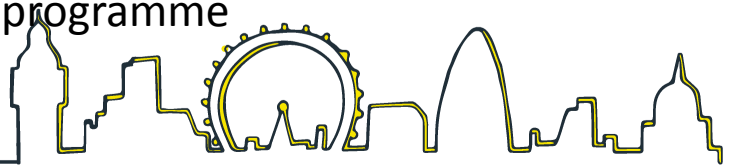
Product = QIS

Process = network, identifying wider priorities, linking with clinical leadership group and other networks/organisations



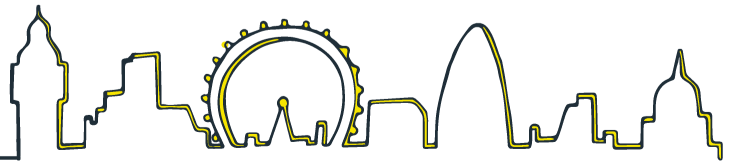
Opportunities to get involved

- SACT passport
- Critical care IVs
- Neonatal nursing QIS
- Theatre nursing QIS
- Older people's nursing network (London)
- CAMHS nursing network
- U&EC nurse educator network & QIS implementation
- Nurse educator network (London) & development programme



“It is the long history of humankind (and animal kind too) that those who learned to collaborate and improvise most effectively have prevailed”

Charles Darwin, 1809 - 1882



Questions?

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natalie.holbery@hee.nhs.uk

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#CapitalNurse

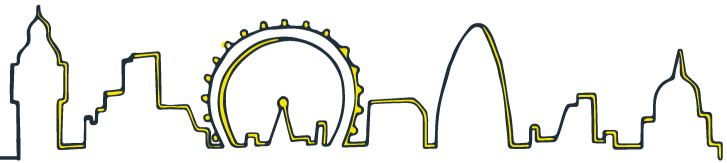
Session discussion

Main points shared

- CapitalNuse gaining momentum
- Process of leading good collaborative change
- Key factors including key stakeholders for collaborative change to work well
- Doing with rather than being done to
- Consider a systems approach

Main points discussed

- Importance of resilience whilst undertaking change
- Change management is not necessarily the same as collaborative change
- Collaboration will take into consideration everyone’s diverse point of view
- Place of networking is collaborative change processes



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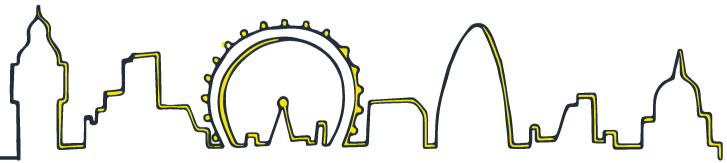


CAPITAL nurse

6. Nursing in Mind – being mindful about nursing: Space to reflect and think

Innovation in mind

The Tavistock and Portman NHS
NHS Foundation Trust

Nursing in Mind – being mindful about Nursing

The ‘Nursing in Mind’ space aims to provide a forum for nurses, from all fields of nursing, who have an interest in developing psychologically minded approaches to Nursing, to consider:-

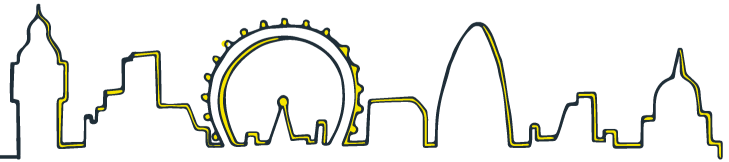
What it is to nurse and to explore the dilemmas and issues that currently affect this practice

- This is a space to Delve beyond the practical realities
- To be Curious about and Explore the “What and How” of what we do
- Why we do it and Might we do it Differently and
- An opportunity to Name and Explore contemporary nursing dilemmas with Colleagues

There is no agenda, no taught component, no reaching after solutions but the provision of a space to pause, think and reflect upon nursing and see what we can identify and discover together

Session discussion

Awaiting session discussion form



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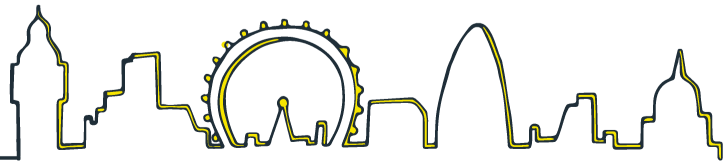
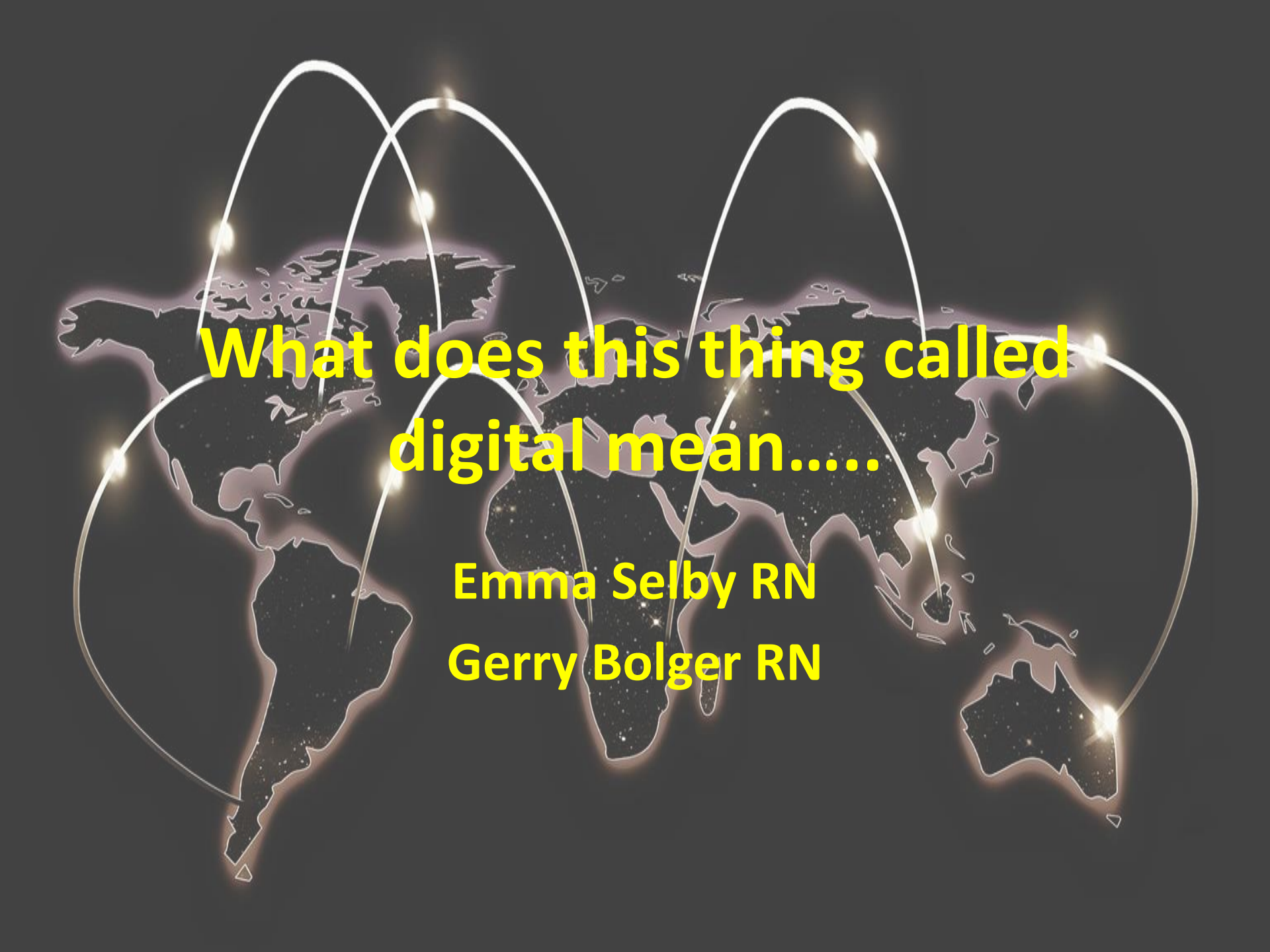


CAPITAL nurse

7. What does this thing called Digital mean to me?



What does this thing called digital mean…..

Emma Selby RN

Gerry Bolger RN

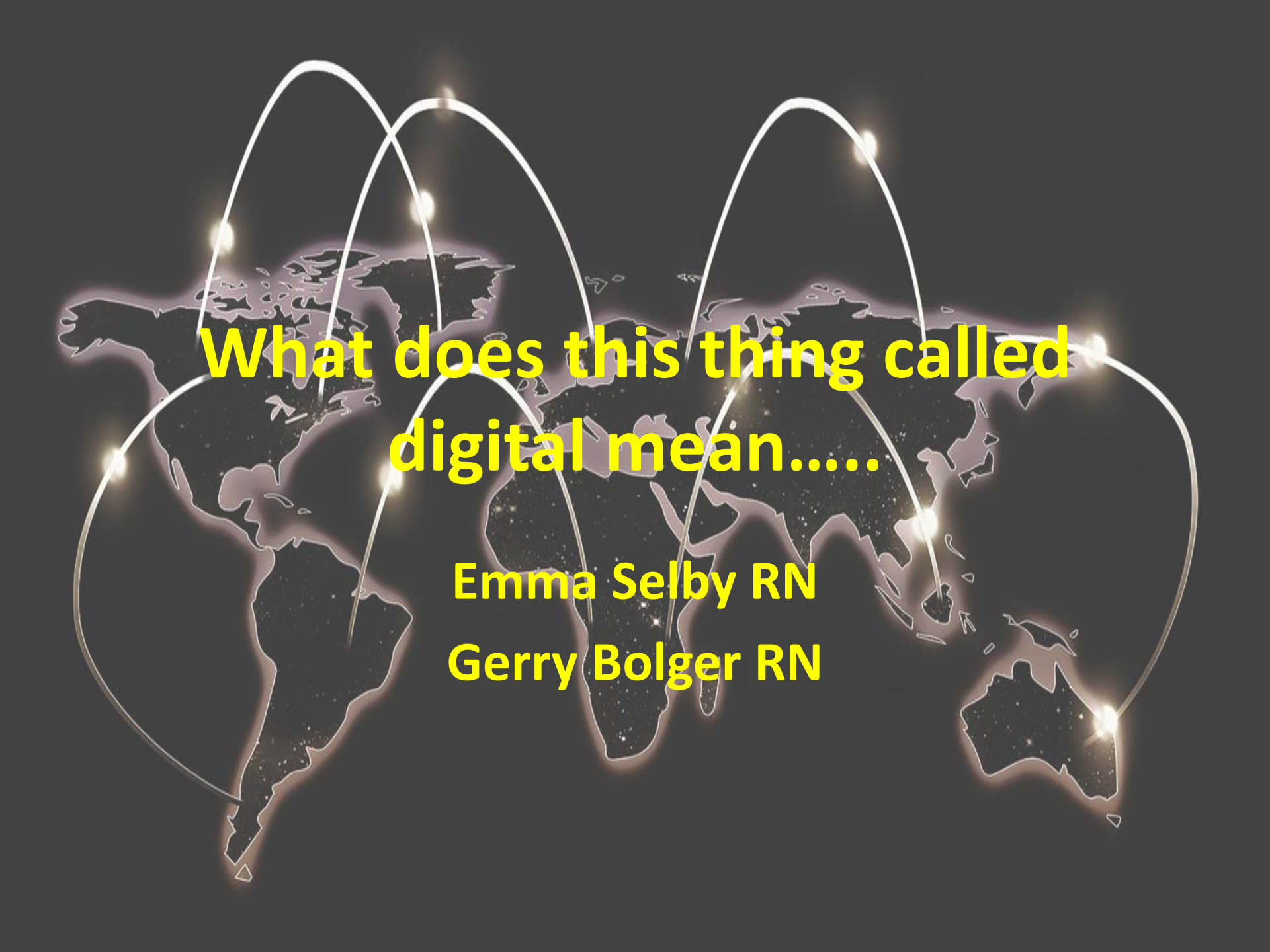
Your input please……..

- We will be using Slido to collate your thoughts
- Your responses are non identifiable
- Remember this is a form of social media and NMC principles apply
- By completing you agree to us to use in writing this session up…

- On your phone/tablet go to Slido.com and enter event code #2320

Answer these three questions:

- 1: Do you understand what being a digital citizen consists of?
- 2: Do you understand what being a digital health care professional consists of?
- 3: If the Digital Agenda could do one thing for you what would it be?



What does this thing called digital mean…..

Emma Selby RN

Gerry Bolger RN

Introductions

- Emma
- @EmmySelby

- Gerry
- @digitalgerry

- So I was at a conference Friday where they introduced each other by stating 3 facts about their co-presentor, two were true and one was fake which was kind of cool

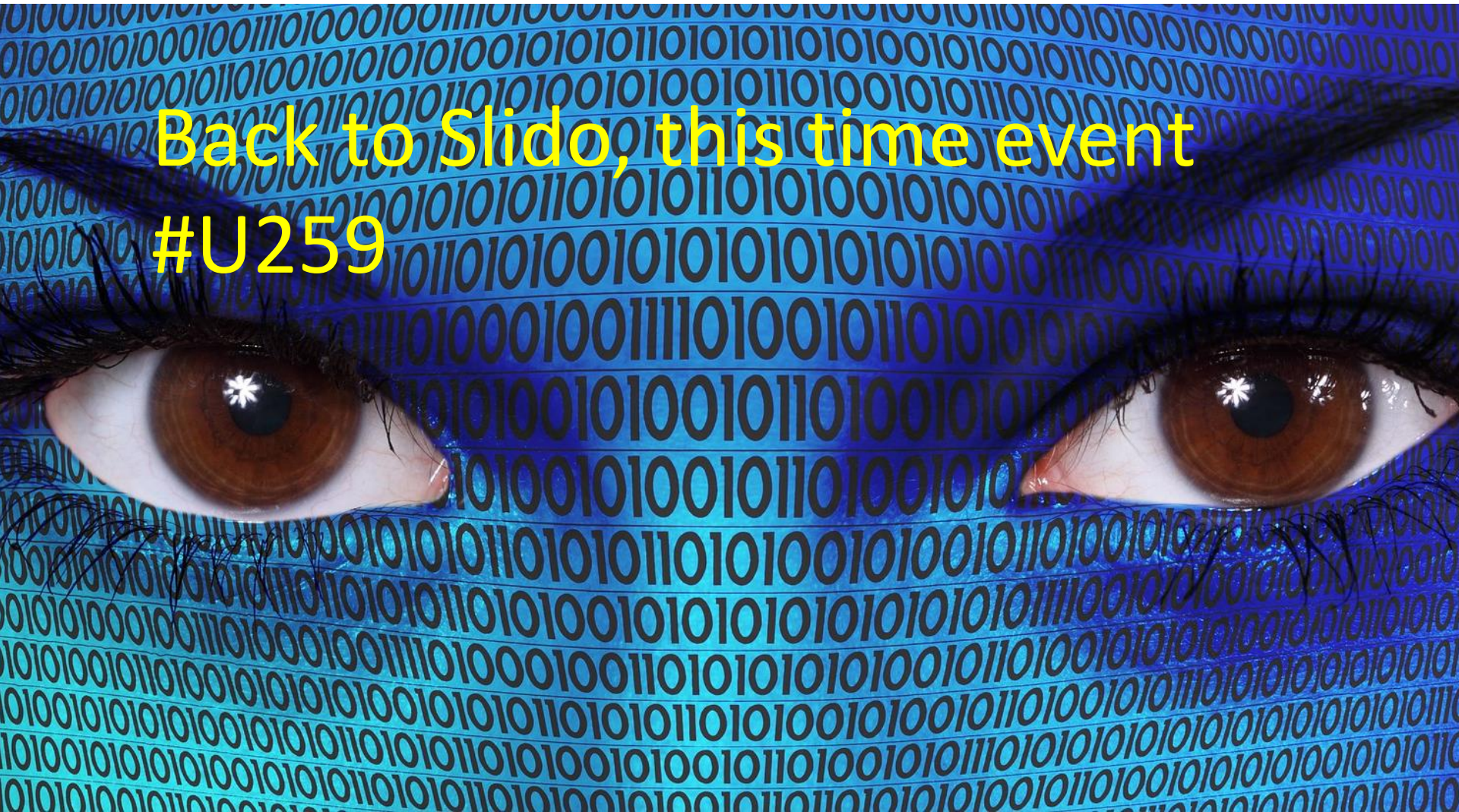
Objectives

By the end of this workshop, participants will understand:

1. What we mean by the ‘digital agenda’ is
2. The implications to us as citizens, health professionals and for patients
3. Consider what you should be doing in regards being “digitally skilled”
4. Consider the implications of improving care for patients regardless of care setting

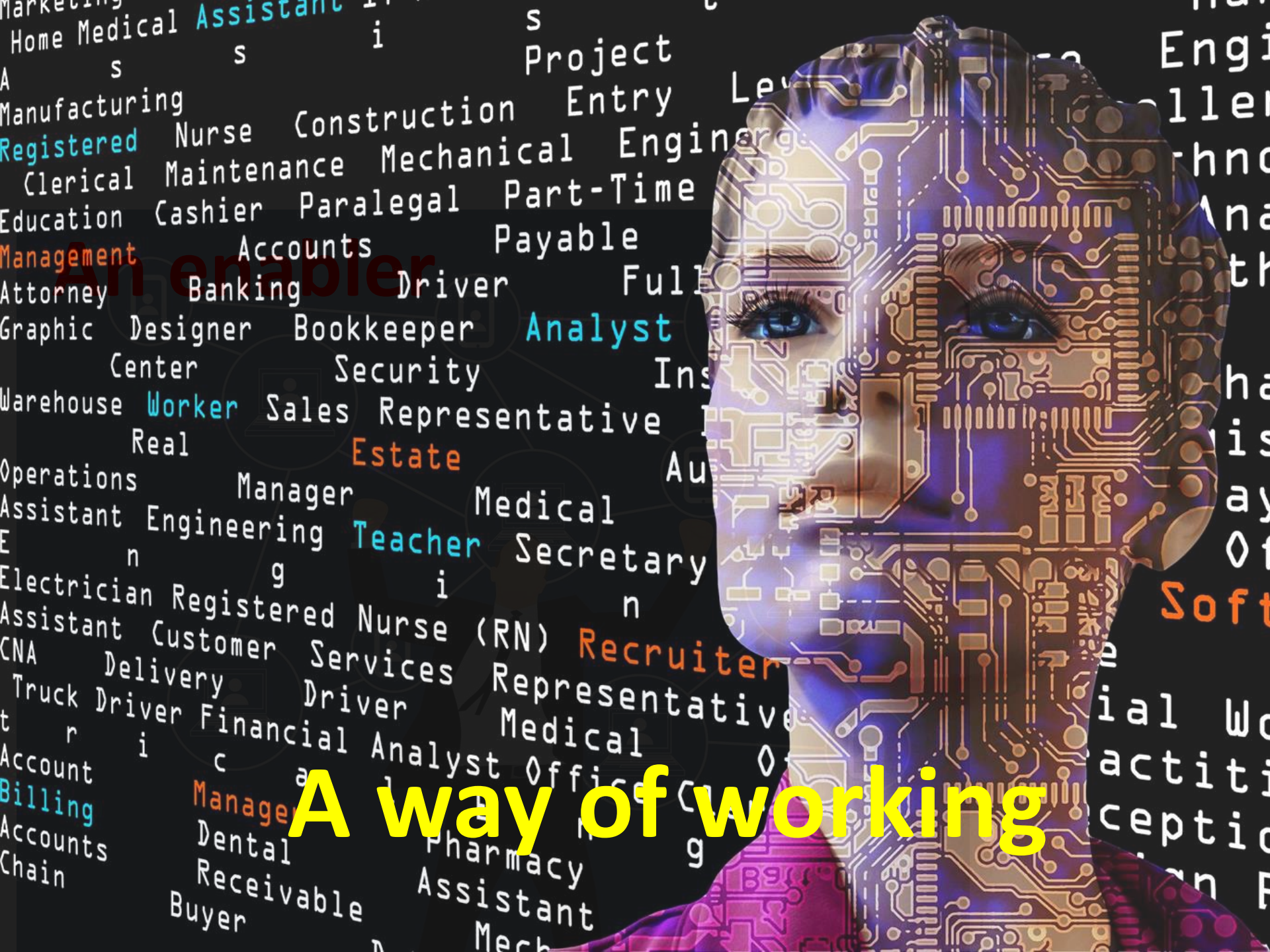
What does “digital” mean to you?

What does “digital” mean to you?

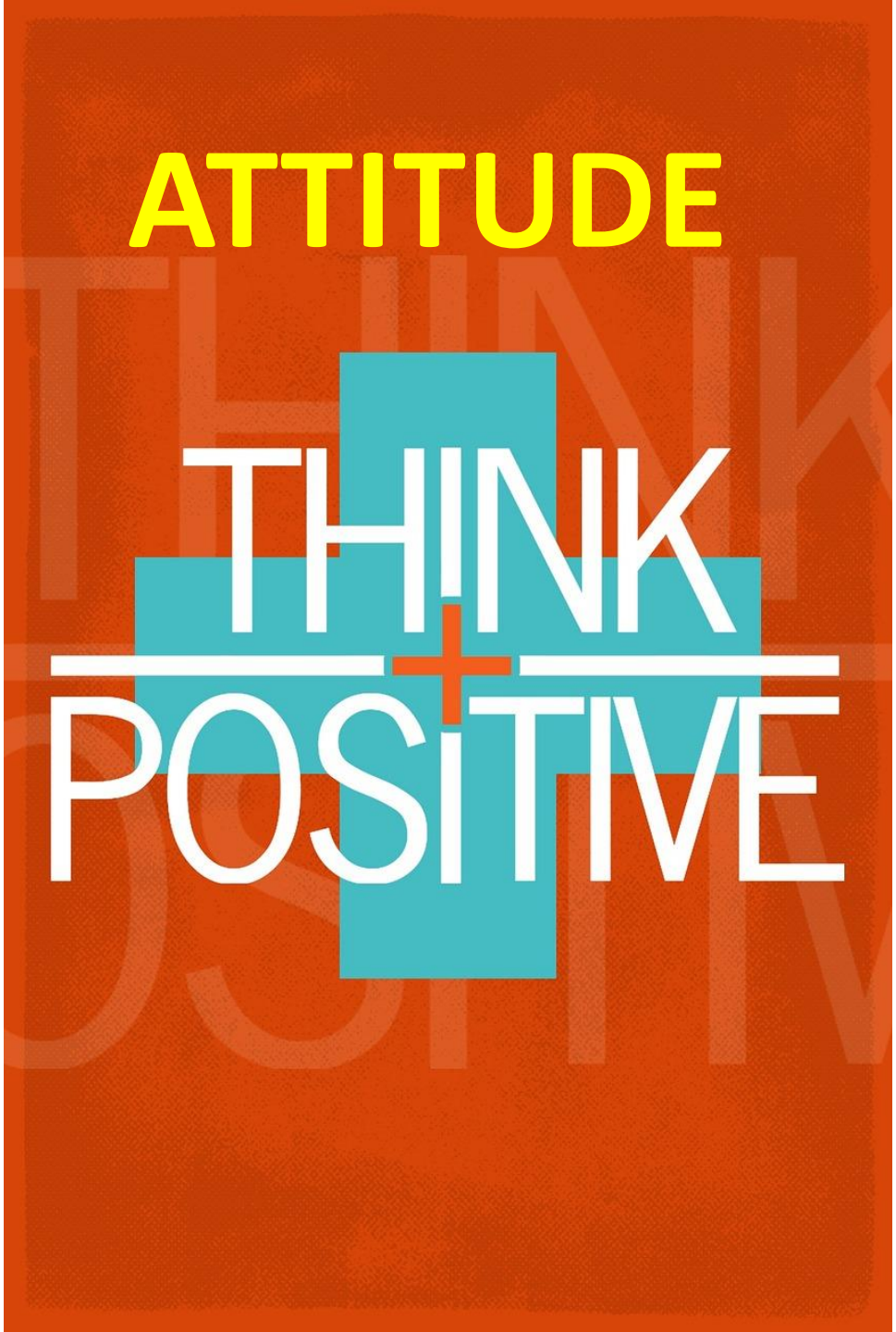


Principally 3 things


Digital is an “enabler”


An enabler
A way of working

ATTITUDE

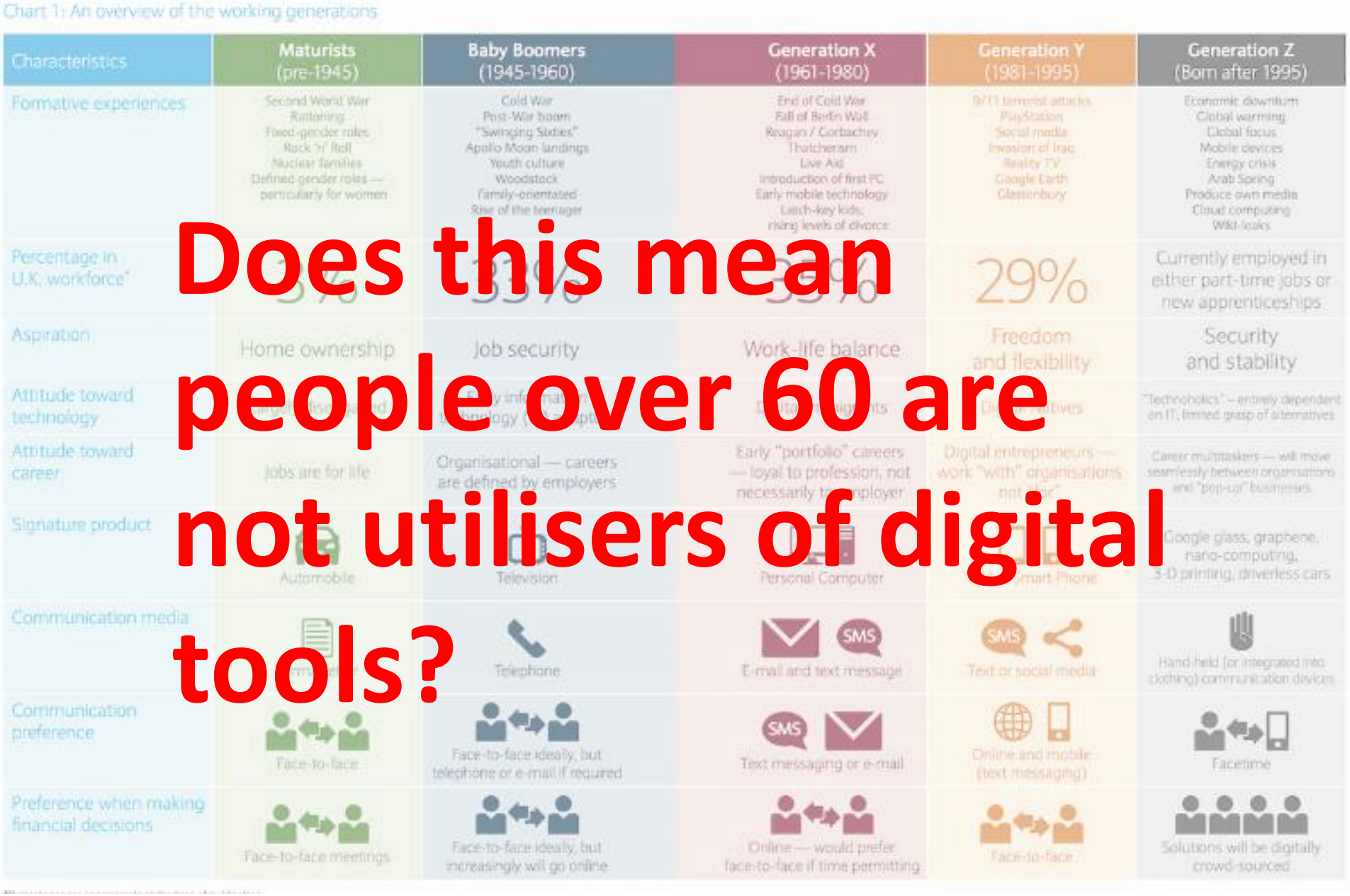


When you were born influences your attitude to embracing digital agenda

Chart 1: An overview of the working generations

Characteristics	Maturists (pre-1945)	Baby Boomers (1945-1960)	Generation X (1961-1980)	Generation Y (1981-1995)	Generation Z (Born after 1995)
Formative experiences	Second World War Rationing Fixed-gender roles Rock 'n' Roll Nuclear families Defined gender roles — particularly for women	Cold War Post-War boom "Swinging Sixties" Apollo Moon landings Youth culture Woodstock Family-orientated Rise of the teenager	End of Cold War Fall of Berlin Wall Reagan / Corbachev Thatcherism Live Aid Introduction of first PC Early mobile technology Latch-key kids: rising levels of divorce	9/11 terrorist attacks PlayStation Social media Invasion of Iraq Reality TV Google Earth Glastonbury	Economic downturn Global warming Global focus Mobile devices Energy crisis Arab Spring Produce own media Cloud computing Wiki-leaks
Percentage in U.K. workforce*	3%	33%	35%	29%	Currently employed in either part-time jobs or new apprenticeships
Aspiration	Home ownership	Job security	Work-life balance	Freedom and flexibility	Security and stability
Attitude toward technology	Largely disengaged	Early information technology (IT) adaptors	Digital Immigrants	Digital Natives	"Technoholics" – entirely dependent on IT; limited grasp of alternatives
Attitude toward career	Jobs are for life	Organisational — careers are defined by employers	Early "portfolio" careers — loyal to profession, not necessarily to employer	Digital entrepreneurs — work "with" organisations not "for"	Career multitaskers — will move seamlessly between organisations and "pop-up" businesses
Signature product	Automobile	Television	Personal Computer	Tablet/Smart Phone	Google glass, graphene, nano-computing, 3-D printing, driverless cars
Communication media	Formal letter	Telephone	E-mail and text message	Text or social media	Hand-held (or integrated into clothing) communication devices
Communication preference	Face-to-face	Face-to-face ideally, but telephone or e-mail if required	Text messaging or e-mail	Online and mobile (text messaging)	Facetime
Preference when making financial decisions	Face-to-face meetings	Face-to-face ideally, but increasingly will go online	Online — would prefer face-to-face if time permitting	Face-to-face	Solutions will be digitally crowd-sourced

Source: Barclays Bank

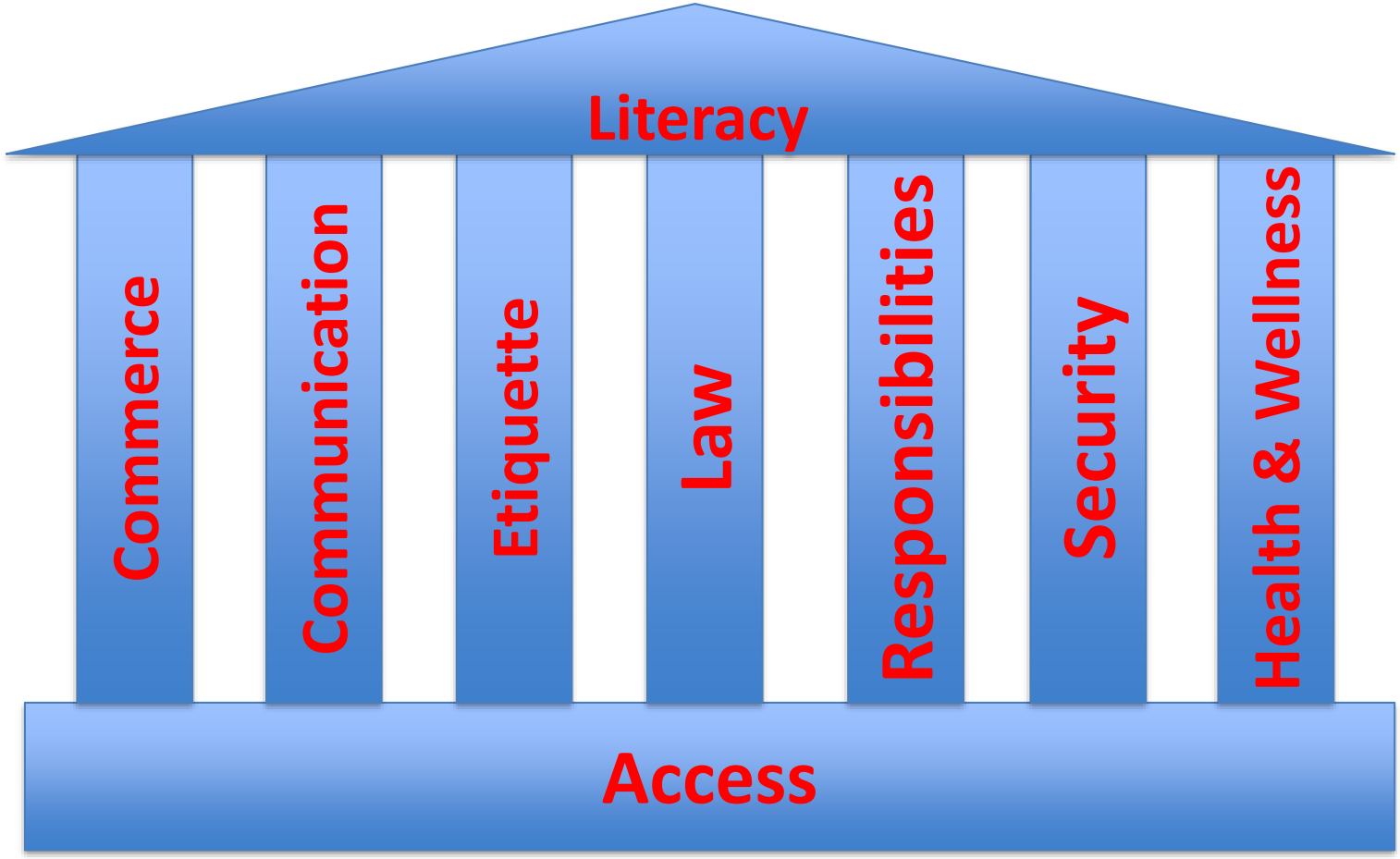


Does this mean people over 60 are not utilisers of digital tools?

Source: Barclays Bank

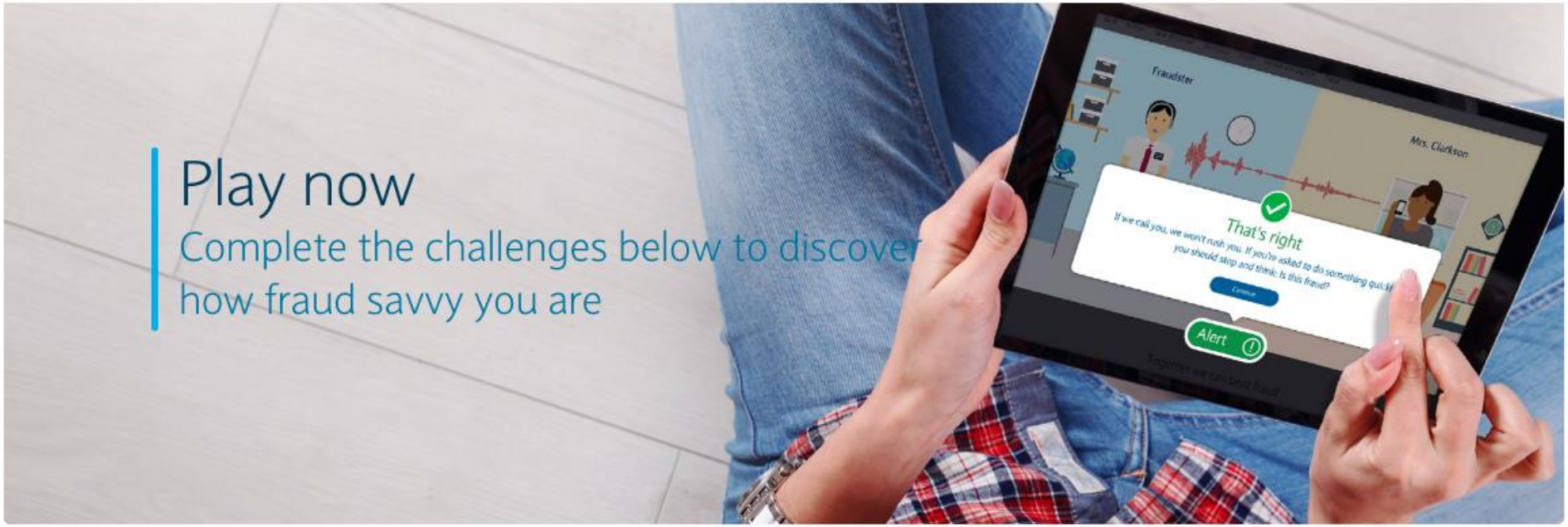
What does it mean to be a **digital citizen?**

Digital citizenship embraces..



Risks & issues

https://www.youtube.com/watch?v=tf9ZhU7zF8s&list=PLtLeT9oxQnvqag7AVKQn1-WYUhKAHzj-b



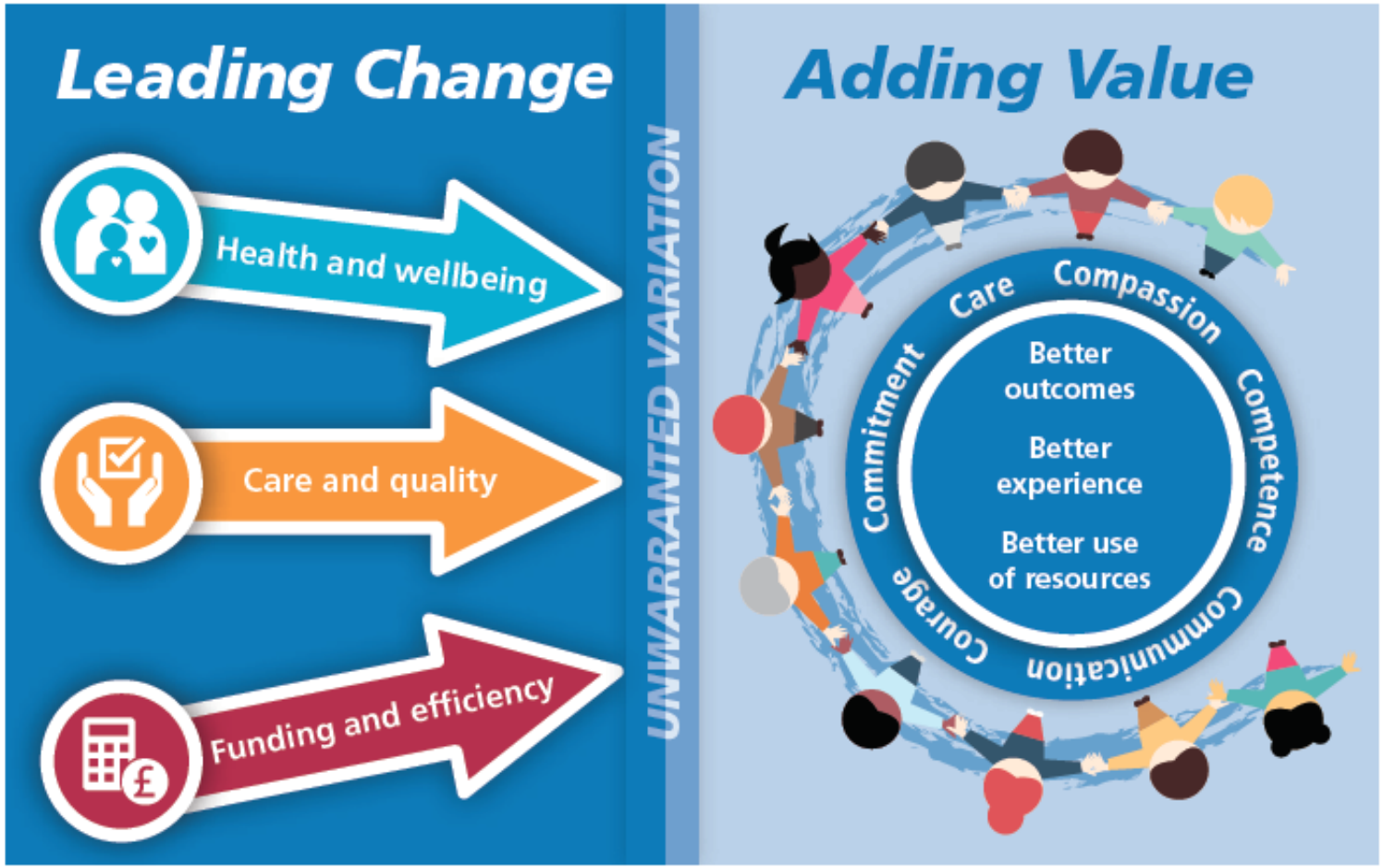
- https://www.barclays.co.uk/security/digitally-safe-quiz/

What does it mean to be a **digital nurse?**

What does it mean to be a **digital nurse?**

Slideo #U259

Nationally…


Leading Change
Health and wellbeing
Care and quality
Funding and efficiency
UNWARRANTED VARIATION
Adding Value
Care
Compassion
Competence
Communication
Courage
Commitment
Better outcomes
Better experience
Better use of resources

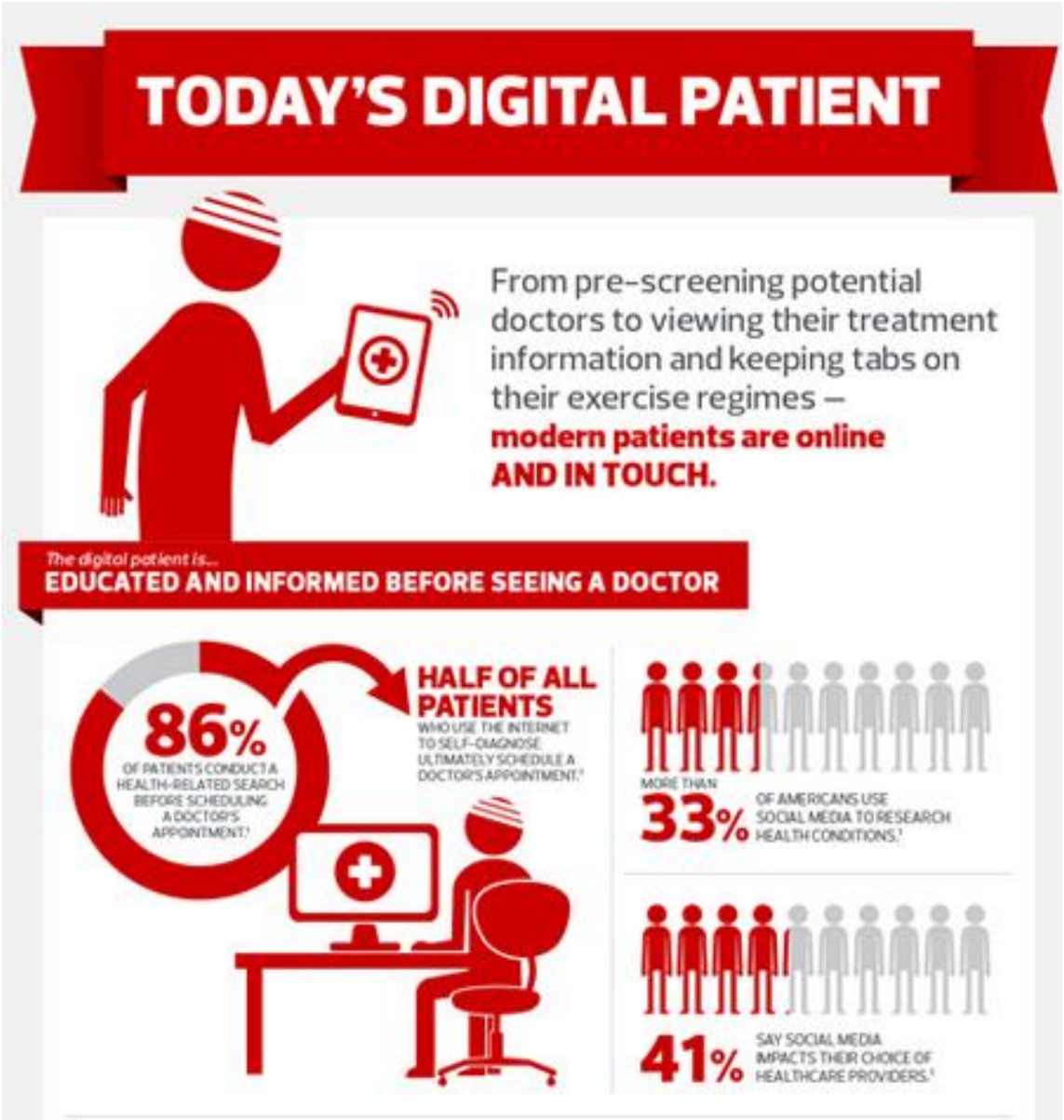
Commitment	Health and wellbeing	Care and quality	Funding and efficiency
1. We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff	✓	✓	✓
2. We will increase the visibility of nursing and midwifery leadership and input in prevention	✓	✓	✓
3. We will work with individuals, families and communities to equip them to make informed choices and manage their own health	✓	✓	✓
4. We will be centred on individuals experiencing high value care	✓	✓	✓
5. We will work in partnership with individuals, their families, carers and others important to them	✓	✓	✓
6. We will actively respond to what matters most to our staff and colleagues	✓	✓	✓
7. We will lead and drive research to evidence the impact of what we do	✓	✓	✓
8. We will have the right education, training and development to enhance our skills, knowledge and understanding	✓	✓	✓
9. We will have the right staff in the right places and at the right time	✓	✓	✓
10. We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes	✓	✓	✓

Experienced based co-design

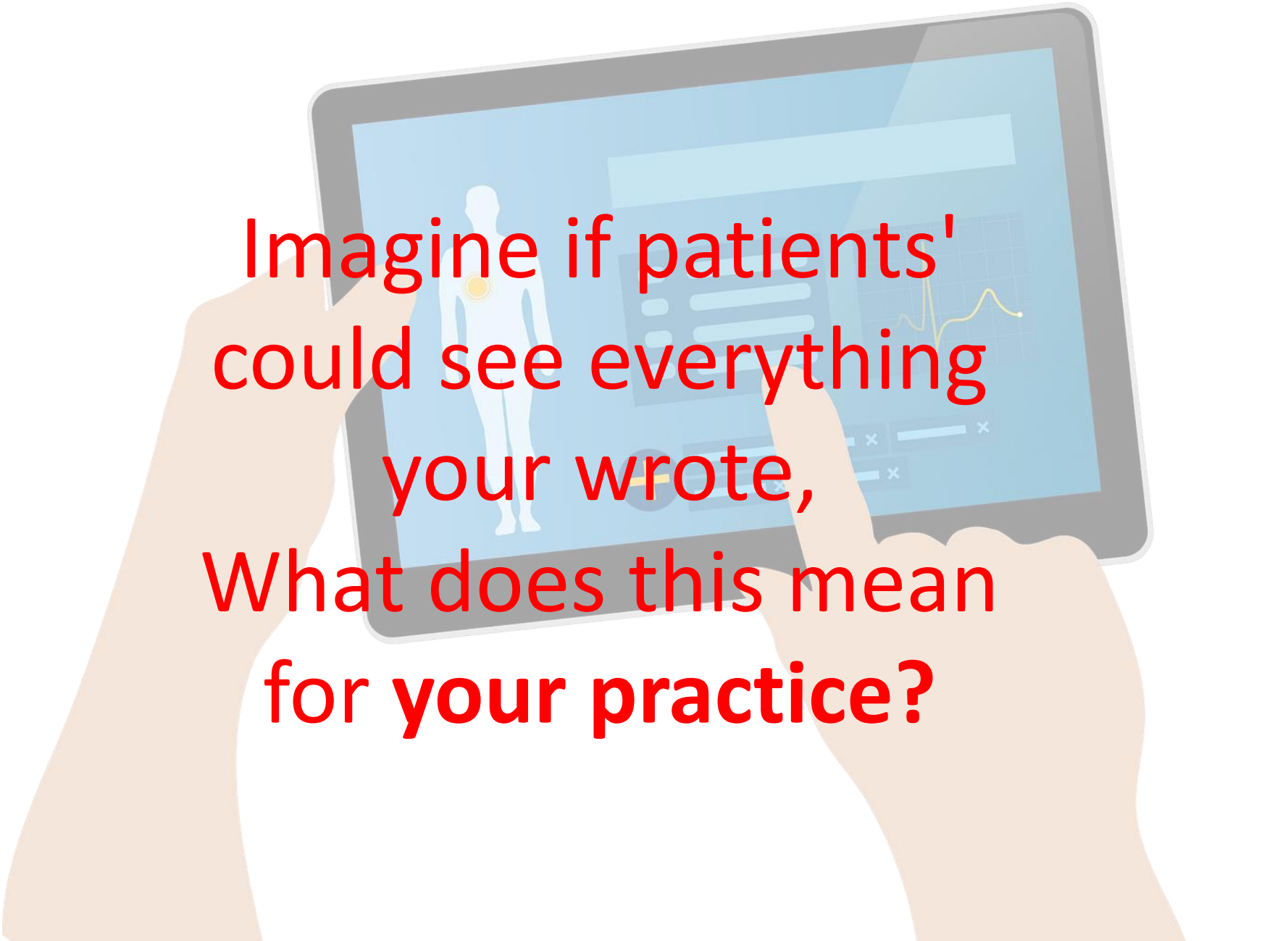
Understanding your role – Digital Literacy

- https://www.youtube.com/watch?v=jFS8D2YKQK8

Digital patient



https://www.youtube.com/watch?v=9oFQzvPUzeU



Imagine if patients' could see everything your wrote,

What does this mean for **your practice?**

Final Thoughts -

There’s one more Slido to book end the day, plus one or two messages to take away

- #2320

Key messages

Thank you for joining us today for our whistle stop tour of digital nursing.

1. Think about how you are and could use digital tools better as a citizen?
2. Find out what is happening in my workplace that and what it means to my practice?
3. What will patients want and where will I get advice & support?

Resources

1. **Twitter**
   - @digitalgerry
   - @emmyselby
   - @anniecoops

2. **RCN:**

   https://www.rcn.org.uk/clinical-topics/ehealth/rcn-digital-ready

3. **Blog**

   www.digitalgerry.co.uk/connectednurses

Engaging with digital transformation agenda – the tools and information - is no longer an option for us as citizens

As nurses you will need to choose to be either the bystander, or be on the highway steering and leading the direction for you and patients.

Bolger & Selby!

www.digitalgerry.co.uk/connectednurses

Session discussion

Main points shared

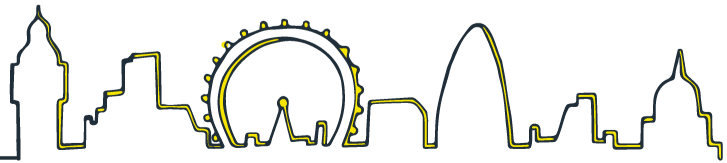
- What it means to be digital in terms of citizenship and healthcare
- Risks and issues of digital media
- What does digital mean for e-nurses

Main points discussed

- Digital users – age dependent
- Implication and pillar of digital citizenship
- Digital impact on healthcare and practice

Next steps/how can CapitalNurse help?

- Developing awareness of digital tools for all nursing/healthcare staff and promote use in workplace/in practice
- Involve nurses in developing digital tools and apps to improve patient care and outcomes



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