



Royal College
of Nursing
Rheumatology Nursing Forum

Clinical nurse specialists: adding value to care

An executive summary



Authors

Clinical nurse specialists: adding value to care was written by Dr Alison Leary and Susan Oliver on behalf of the RCN, its members and staff.

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Introduction

Nurses are the largest component of the NHS workforce and frequently the subject of significant change and challenge in terms of their role. Recent world-wide economic events have forced service planners and commissioners to look carefully at the contribution nurses make delivering high quality, effective and person-centred care. Of all the developments in nursing, the role of the specialist nurse has been one of the most exciting, but also one of the least understood and valued. The Royal College of Nursing (RCN) has made securing a sustainable future for specialist nurses a major goal of its strategic campaigning around national parliamentary elections and when influencing comprehensive spending reviews for health and social care funding (RCN, 2010).

What does this report contain?

In March 2009 the RCN acquired a licence for Pandora, a software-based workload modelling tool, to record the complex activity of clinical nurse specialists (CNSs) working in the field of rheumatology. The aim was to examine and capture the essential contribution that rheumatology nurse specialists (RNSs) make towards high-quality care. This was a national project spread over 10 strategic health authorities in England and across four countries lasting for one year from March 2009.

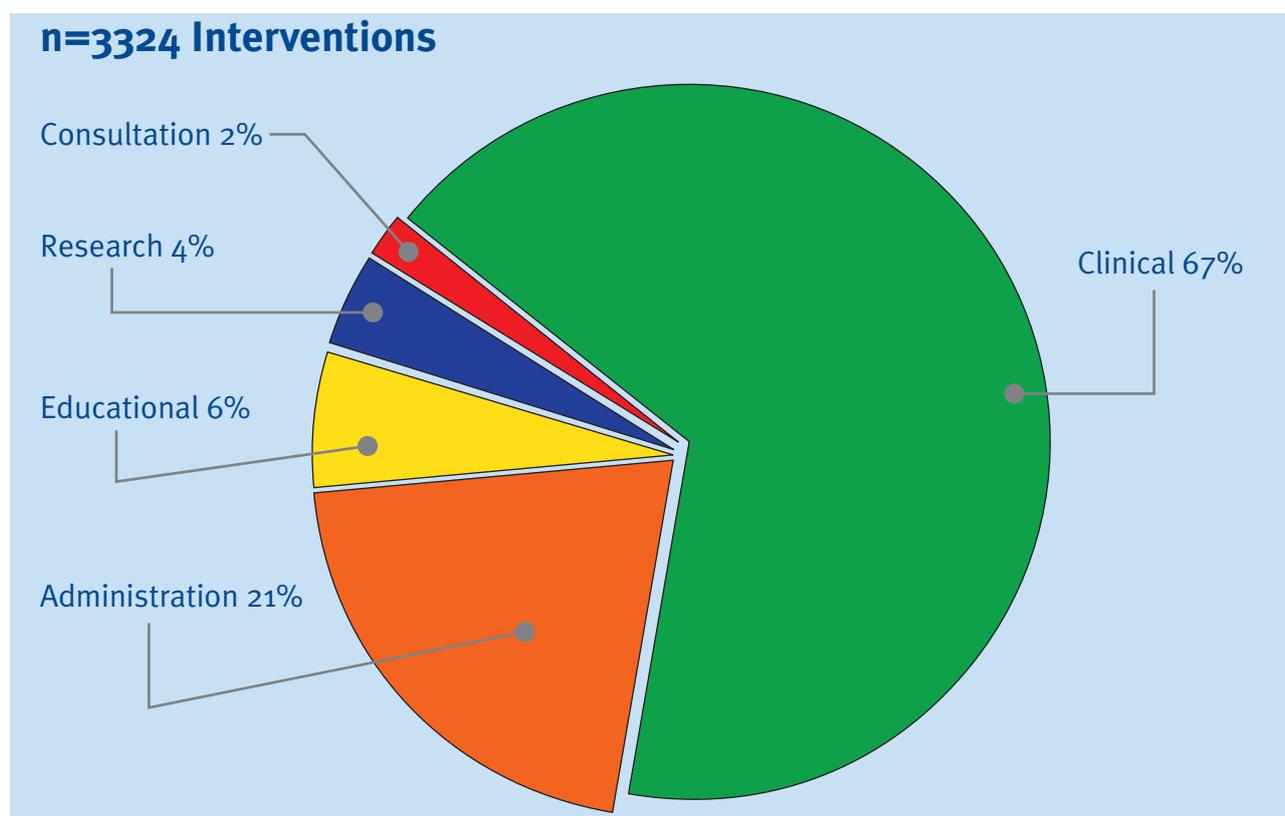
The work of CNSs is recorded in Pandora as a series of events. Each event has eight dimensions capturing the complexity of the work. There is also an opportunity to record a narrative for each event which fully describes the event in more detail and could be subject to qualitative analysis.

The RCN recruited 99 participants for the study via the Rheumatology Nursing Forum website. In all, they recorded 3,324 intervention events, representing 101 nursing days. This is a significant data set and a valuable addition to increasing understanding of the CNS role.

The following report sets out the results of the above study and makes recommendations for investing in the CNS role, and in particular supporting CNSs in practice. It also shows that CNSs are saving the NHS money every day through their innovative approach to care.

What are the findings?

The study found that the majority of the interventions by RNSs were clinical (67%) and this compares with 68% in a larger national study (Leary et al., 2008). For each of the 2,227 clinical events, Pandora records the type of intervention. The majority of the clinical interventions were physical (66%) in nature. 23% of these physical interventions consisted of specialist musculoskeletal examination (Hill and Pollard, 2004; Hill, 2006) which required the application of vigilance (Mayer and Lavin, 2005), clinical acumen beyond case management and brokering (Kanter, 1989), and treatment decisions. 22% involved enhancing self-management principles and managing unresolved symptoms using specialist knowledge and assessment. 27% of this physical work is the management of medication, including dealing with toxicity and rescue work of iatrogenic events (i.e. an unintentional adverse consequence of treatment).

Figure 1: Interventions by type, shown as percentages

However, administration accounts for 21% of the workload. This is in keeping with the findings from the rheumatology nursing survey (RCN, 2009a) which also demonstrated that clinical nurse specialists in rheumatology carried the burden of administration for their services. If this expert nursing resource is to be optimised, simply providing clerical support would appear to release an extra 6.25 hours per week, whole time equivalent (WTE).

Care settings

Outpatient work

In keeping with national studies of CNSs, it was found that much of their work is performed in the outpatient setting or on the telephone (Leary et al., 2008). In this study, the group overall recorded 51% of their interventions as outpatient work.

The average outpatient workload of the RNS is a mean of 16 patients per week. The vast majority of this work is outpatient follow up. If this work was coded under Healthcare Resource Group (HRG) 4 (DH, 2009), this activity would represent £72,128 pa per nurse WTE based on a 46 week year. By investing in RNSs to undertake routine follow-up, consultants are released to undertake new patient appointments. Using HRG 4 this represents an additional saving of £175,168 pa per nurse WTE.

Telephone consultations

Much of the telephone work undertaken was found to be clinical in nature, which is in keeping with studies of other groups of CNSs. RNSs also explicitly record much of their telephone work as advice line work. This is a departure from previous findings but may be a consequence of changes in work practice following the publication of guidance on managing telephone consultations (RCN, 2006).

Hughes et al. (2002) demonstrated the value and cost effectiveness of telephone advice for patients in rheumatology. Such work also improves the quality of care, as identified in the NRAS survey and Department of Health strategies on encouraging self-management principles (DH, 2008).

Authors such as Hughes et al. (2002) and National Rheumatoid Arthritis Society (2006) demonstrate that if patients did not have access to specialist nursing advice on the telephone, 60% state they would have requested a GP appointment. In the Pandora group, 879 clinical phone calls were made. Based on the work of Hughes et al. (2002), the figure of 60% would represent 526 events in which patients would have sought advice from their GPs. The average cost for a GP appointment is £60 (NAO, 2009; PRSSRU, 2005), so this represents a cost saving to primary care services of £72,588 pa per nurse WTE.

Psychological support

18% of all clinical events were psychological in nature. Most of these psychological interventions were around management of the anxiety and distress common in patients with rheumatoid arthritis (Pincus et al., 1996; Martindale et al., 2006). Distress and anxiety could be a consequence of a new diagnosis, uncontrollable pain and loss of function, or the unpredictable nature of the disease and fear of the unknown. Narrative data from the study shows that RNSs use their specialist knowledge and empathy to help patients develop coping strategies.

Typical patient outcomes

Analysis of narrative data and the wealth of information obtained through this study show that there are discrete patient outcomes from RNSs' practice. Pandora records outcomes from a developed consensus list. The "top five" most used outcome of each event documented in Pandora were as follows:

- alleviation of suffering – physical assessment and specialist symptom management: 21%
- assessing and meeting information needs of patients: 19%
- rescue work – particularly managing the toxicity of drugs: 14%
- alleviation of suffering – psychological: 11%
- access to a key contact/knowledgeable professional, or brokering rapid access to another professional (i.e. rheumatologists): 11%.

Conclusions

This study presents compelling evidence of the impact of specialist nurses in the field of rheumatology and makes several clear recommendations for investment in specialist nursing across all areas of practice. In summary, specialist nurses in rheumatology:

- apply specialist and specific knowledge and skill to manage physical and psychological morbidity
- alleviate physical and psychological suffering inherent in this long term condition
- use vigilance of physical symptoms and drug toxicity to trigger rescue work
- co-ordinate complex care and refer onto other professionals as part of the multi-disciplinary team (MDT), particularly the community services
- provide patients with a contactable, knowledgeable, accessible professional
- provide clinical expertise to patients, families and other professionals, e.g. GPs
- resolve unsatisfactory experience
- represent good value for money, through reducing costs in primary care and saving consultants' time.

Key recommendations

Releasing time to care

This study demonstrate that 6.25 hours of the specialist nursing week is spent on clerical work that could be performed by a clerical support worker. Providing such support would release more time for clinical work and would be at least cost neutral if activity were coded appropriately.

Metrics

This study has identified several areas that are potential metrics for RNSs' practice. These are in the areas of vigilance and rescue, psychological care and physical review. Measurement of care and outcome in these areas would demonstrate the added value generated by the RNS role and enable a more sophisticated system for commissioning of services for patients with rheumatological conditions.

Activity and cost

RNSs appear to represent significant benefits to the organisation, including patient outcome and cost benefit. These are currently invisible to most organisations. The study found that the outpatient work done by RNSs is worth £72,128 pa per nurse WTE, and saves £175,168 pa per nurse WTE by freeing up consultant appointments. Telephone consultations also save £72,588 pa per nurse WTE by reducing the number of GP appointments.

This reflects earlier work done by the RCN on the contribution of nurses towards HRG costs (RCN, 2009b). Non-consultant-led work is not consistently recorded or attributed to specialist nurses in all NHS Trusts. The Payment by Results tariff for 2010/11 appears not to recognise nurse-led activity, including telephone work. The Department of Health needs to review this situation as this will make specialist nurse posts vulnerable during the impending financial challenges.

Prevention of unscheduled care is poorly recognised in the work that this group of nurses undertake because the specialist area is not the focus of national research. Further research is needed to explore the cost-benefit analysis of nurse-led services against equivalent care provided by at least the equivalent of a doctor with some level of knowledge in the field (for example a medical registrar).

Prescribing

This study has demonstrated the value of prescribing in the management of symptoms, side effects and drug toxicity. This includes recommending prescribing to GPs using specialist knowledge. More detailed research is needed to explore the contribution RNSs make using their prescribing knowledge.

Education

Expertise applied to the management of these patients requires a high level of education and competency. Therefore a competency framework should be developed as currently Skills for Health (www.skillsforhealth.org.uk) encompass only two competencies for rheumatology nursing, embedded in those for long term conditions.

Succession planning

The complex and high-level expertise needed to fulfil this role require a number of years to gain. The findings of the RCN rheumatology survey (RCN, 2009a) demonstrate that 22% of such nurses have the minimum of a master's level education and 26% were prescribers. However, over 40% of the nurses were more than 50 years old, and the mean number of years since qualification was 24. This means that succession planning is vital to maintain quality and services in the future.

More information

For a full copy of the report or to find out more about how the RCN is working to shape nursing practice, please contact the RCN Nursing Department on 020 7647 3741, or visit the RCN Rheumatology Nursing Forum community at www.rcn.org.uk/rheumatology

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