EFN COMPREHENSIVE REPORT

Nurses' Added Value in the Health and Social Care Ecosystems

Best Practices submitted to Tour de Table (TdT)
2006-2018

A Compendium of Best Practices from
35 Countries in Europe

December 2018

EUROPEAN FEDERATION OF NURSES ASSOCIATIONS

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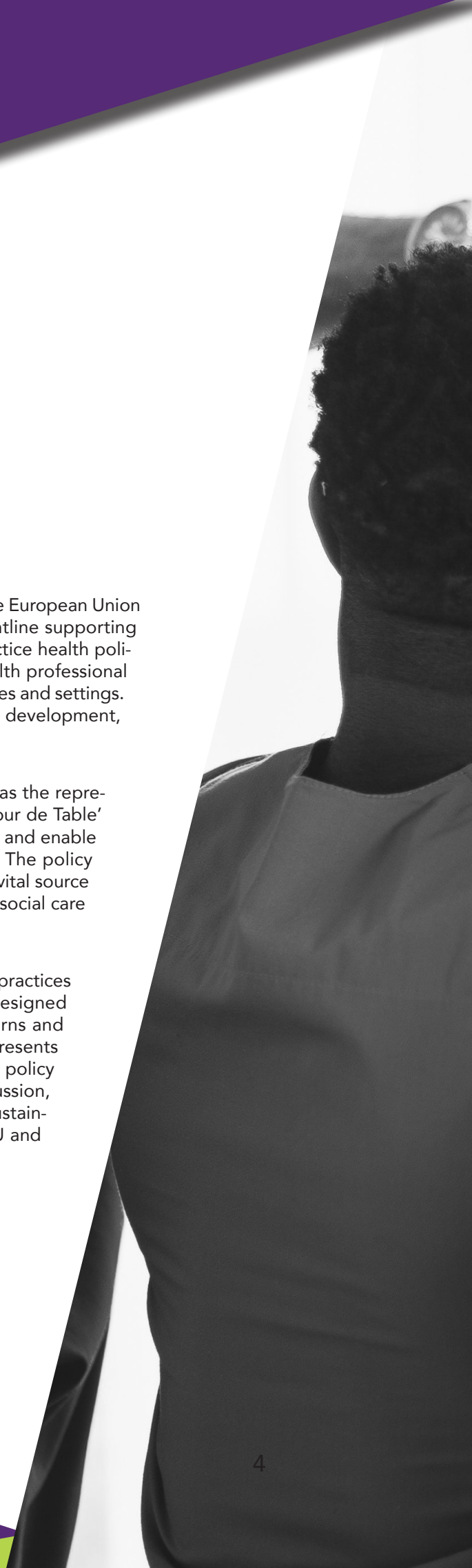
EFN BRUSSELS

Executive Summary

Ensuring the provision of safe and quality healthcare in the European Union (EU) relies on those healthcare professionals on the frontline supporting and informing the development of successful, fit-for-practice health policies. Nurses are the single largest and most trusted health professional group, delivering the majority of healthcare across countries and settings. 'As such' they are ideally placed to input in health policy development, drawingfrom their real-world experience on the field.

The European Federation of Nurses' Association (EFN), as the representative body for nurses in Europe, has long used its 'Tour de Table' as a key policy support mechanism to gather intelligence and enable the exchange of best practices among its membership. The policy reports developed from this intelligence gathering are a vital source of factual, comparative data and insights into health and social care in the European Union and Europe.

The present document represents a compendium of best practices from across 35 countries in Europe members of EFN, designed to draw cross-cutting conclusions, link up shared concerns and showcase best practices for mutual learning. The EFN presents this document as a resource for healthcare stakeholders, policy makers, clinicians, patients and the public to invite discussion, policy response and exchange of practice to build the sustainability of the health and social care ecosystems in the EU and Europe.



Twenty EFN Tour de Table reports dating from 2006 to 2018 have been reconsidered in light of recent health and social care and policy developments in Europe. These have been synthesised in the present document to draw key conclusions and group best practices in five areas: prevention, primary care, integrated care, workforce and patient data.

Nurses across Europe are on the frontline of health and social care and uniquely positioned to feel the pulse of present and future developments, both positive and concerning. Nurses' real-world experiences from the frontline are a vital resource to inform and support policy making, and essential in ensuring effective, accessible and resilient health and social systems in Europe.

Drawing on the current synthesised report, based on the EFN Members' input through the Tour de Table policy support tool, the EFN recommends to the European institutions, Governments and relevant health stakeholders to:

1. Invest in capacity building to empower nurses as the frontline healthcare professionals delivering the majority of healthcare to citizens across Europe.

3. Support the exchange of best practice on the five themes identified in the present report, to facilitate mutual learning among countries.

5. Develop evidence-based decision-making capacity in nurses to support them fulfil their extended health remit, for the benefit of patients, families, and communities across Europe.

.2. Promote the development of advanced nurse practice with extended prescribing rights to ensure safe and efficient access to medications for patients.

4. Provide support for primary care nurses to enable delivery of preventative and curative care closer to where citizens work and live their lives.

The EFN Members call for coordinated action among all relevant EU health stakeholders to ensure nurses and nursing meet society's mandate to protect and promote the health of Europe's citizens, through the provision of safe and high-quality nursing care across settings, regions and countries.

1. Methodology

1.1 The EFN Tour de Table

Facilitating the exchange of knowledge, experiences and developments among the EFN membership is a very much valued function of the EFN bi-annual General Assembly meetings. A key policy support mechanism to achieve this has come to be known as the EFN Tour de Table. At each General Assembly of the EFN, the Tour de Table policy support mechanism provides the opportunity for the EFN Members to share information and best practices on a specific topic of political concern; as well as key issues and developments of national importance. EFN Members value the opportunity to share their experiences with their colleagues from across Europe, learn from each other's ongoing developments at national level, and how they can provide support to each other.

1.2 Data sources

Data for the Tour de Table originate from all the EFN Members and are collected both online and during the face-to-face General Assemblies. The EFN Members are asked to feedback on key topics of policy interest by completing a semi-structured, standardised data collection form. EFN Members are also given the opportunity to verbally present and discuss their innovations with other EFN Members present at the General Assembly.

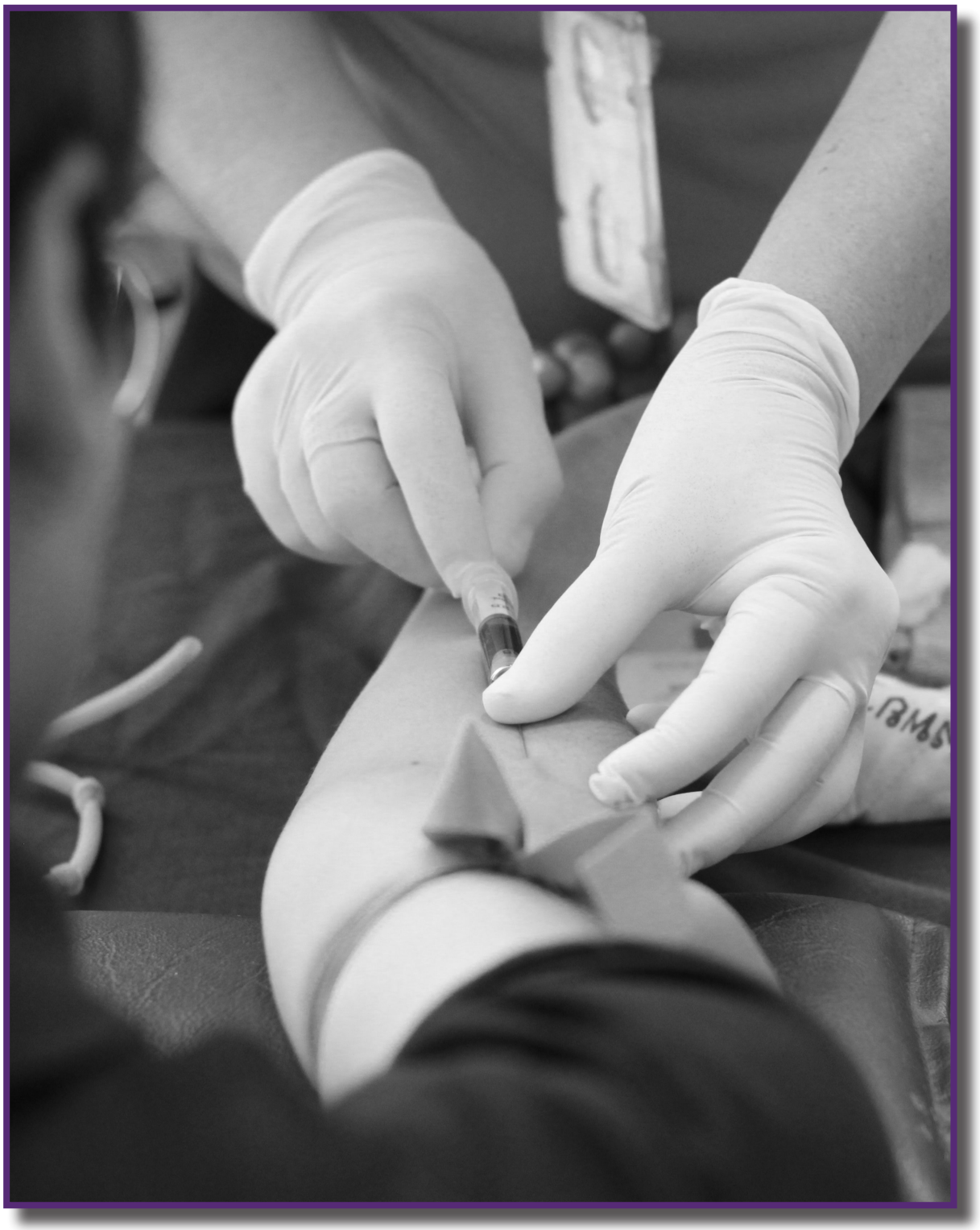
Following each data gathering exercise, key messages, best practices and national developments are analysed thematically and presented in detailed policy reports. These reports are shared among the EFN Members not to compare, rank or show off but rather to inform the work of the EFN Members in different countries and enable connections among those Members that can support each other in their work. The policy reports developed from this intelligence gathering are a vital source of factual, comparative data and insights into health and social care in Europe and the EU.

2. Best Practices led by Nurses

Twenty EFN Tour de Table reports dating from 2006 to 2018 have been reconsidered in light of recent health and social care and policy developments in Europe. These have been synthesised and presented below, drawing key conclusions and grouping best practices under the five thematic areas of prevention, primary care, integrated care, workforce and patient data.

2.1 Prevention

Prevention is at the heart of nursing care across Europe and a key feature of nurses' daily work. Nurses have historically argued strongly for the importance of prevention, but investment in prevention is yet to reach optimal levels. Because of the nature of their profession, nurses are ideally equipped in promoting public health and collaborating with other health and social care professionals; supporting patients and citizens in achieving their health goals and creating a healthier population. The EFN Members are very active in the prevention agenda, with key functions across Europe including health education, health promotion, vaccination, infection prevention and antibiotic stewardship.



Vaccination

Nurses are the frontline staff largely responsible for delivering safe and effective vaccination programmes to communities across Europe, yet rarely get formal recognition for this life-saving endeavour. In addition to administering vaccination, nurses have additional roles relating to educating the public, identifying vulnerable groups, raising awareness and promoting uptake among those who stand to benefit. Nurses deliver vaccination-related nursing care in diverse settings ranging from acute hospitals, schools, older persons facilities, workplaces and peoples' homes. However, only a small proportion of vaccination activity takes place where it would be most convenient and accessible to citizens. In Cyprus, for example, nurses perform vaccination in diverse settings as Children Welfare Clinics, schools, refugee – immigrants' camps, prisons, travellers and adults' vaccination centres, rural and urban community centres, hospitals, Outpatients Departments and primary health care settings of the public sector, i.e. urban and rural health care centres. Furthermore, in Estonia, vaccination can be carried out by any nurse who has undergone additional training and has a valid certificate. Here, nurses are responsible for vaccination of all ages in the family doctor centre and in schools, making corresponding reports and informing the patients of the forthcoming vaccinations. An electronic vaccination passport, which can be found in the person's own digital health records, will soon be applied. Currently, children vaccination rates are 92-93%, and influenza vaccination % is growing every year, representing a major contributor to nursing health promotion activities.In Norway, for example, the child vaccination programme is prescribed, administrated and performed by nurses in public health centres. For children up to 5 years old, nurses administer vaccination within the school health services in elementary, secondary and upper secondary schools; while for adolescents and young people this is completed in health centres. This nurse-led service is part of the municipalities' statutory public health service that covers the needs related to health promotion and preventive care. Other areas where nurses conduct vaccination include the annual vaccination campaigns against flu, at centres for travel medicine, and in refugee health services. This illustrates that current vaccination provision remains health service/professional centred, rather than people centred, and a drastic shift in this regard is warranted. And nurses, as the largest and most trusted health professional group, have a key role to play in this endeavour.

Guarding against pandemics

Nurses also have a key role to play in preventing the spread of highly infectious diseases and stopping the development of pandemics. During the Ebola crisis, nurses held a crucial role in combatting and containing the situation; even when it meant placing themselves and their families at risk. Data collected by the EFN in 2015, at the critical Ebola crisis period, through an online questionnaire that reached health professionals from 23 countries in Europe and secured 1800 responses from frontline working in hospitals, Ebola reference hospitals, in the community and in elderly care homes, revealed that from the perspective of the frontline staff there were varying degrees of preparedness for Ebola and other infectious diseases of high consequence (IDHC) among countries in Europe. It is significant that frontline nurses reported a lack of policies to protect them from working overtime during such pandemics. It is also especially worrying that a significant proportion of nurses who have cared for a patient with Ebola noted feeling stigmatised. The Ebola experience showed that frontline nurses' views are a critical resource in assessing the preparedness level of different countries at the level of everyday practice -there where patients are cared for and staff risk exposure to dangerous infectious diseases. It is vital that policy-makers pay attention to the voices and messages of frontline staff as it is they who ultimately act as the guardians against the threat of IDHC in the EU and Europe. Investing in capacity building for staff taking on such roles is desperately needed.

Antibiotic stewardship

From the perspective of the EFN Members, antimicrobial resistance (AMR) is one of the biggest threats to health in Europe today. AMR leads to longer hospital stays, higher medical costs and increased mortality. Initiatives promoting prudent antimicrobial prescribing and management are generally lacking nurses' involvement, which can substantially increase the extent to which these strategies can improve patient outcomes. Nurses' leadership and contribution to multi-disciplinary teams adds both impact and balance to the delivery of care and reduction in poor patient outcomes. As nurses have closer and more frequent contact with patients and carers, often undertaking the role of care coordinator, they are ideally placed to lead antimicrobial stewardship programmes. Nurses' impact on AMR is immediately visible in their role as link nurses and advanced nurse practitioners (ANP). In these roles, initially popularised in the United Kingdom but now widespread across Europe, nurses acquire a better overview of all the prescriptions patients can be on and can take appropriate action accordingly. Such work is of special importance in elderly care settings, where patients are often prescribed too many different antibiotics. As nurses are getting more active in medication prescribing, they can inform clinical decision-making related to prudent use of antibiotics, reducing unnecessary and excessive use and importantly taking up medication reconciliation actions. Following the Council Conclusions, the revised EU Action Plan against the rising threats from AMR, the progress report made available in early 2015, the evaluation of the 2011-2016 Action Plan highlighting the need to support and assist Member States in developing and implementing national action plans, and the updated "European One Health Action Plan against AMR", published in June 2017, the EFN asked its National Nursing Associations (NNAs) actively engaged in combating AMR to provide best practice examples. This information can be complemented with a range of statements provided by the EFN Members in the occasion of the European Awareness Day on Antimicrobial Resistance.Nurses' role is also crucial in the team work required to deliver AMR solutions, as is the role of the Link nurses on antimicrobial stewardship to motivate the entire ward team combatting AMR and keep the team alerted, including on hand hygiene. The UK is an example of such inter-professional collaboration, where the Royal College of Nursing (RCN) has piloted and evaluated a bespoke Political leadership programme for antimicrobial stewardship in collaboration with the Royal Pharmaceutical Society and Public Health England. This programme brings together nurses, pharmacists and health protection staff whose role includes responsibility for antimicrobial stewardship. Its aim is to develop health care workers with common responsibilities with political leadership skills to support systems leadership and engagement to deliver the local and national AMR strategies. In 2015 they launched a guide to effect hand washing, seen as the most important measures for infection prevention. Likewise, the Chief Epidemiologist for Iceland has recently published a guideline to promote hand hygiene. In Sweden, nurses are involved in the main arenas where AMR is discussed and planned. For instance, they participate in STRAMA – the Swedish strategic programme against antibiotic resistance, that plays a central role in AMR policies, having a huge political support and commitment, became an advisory body to the Public Health Agency of Sweden. The Public Health Agency of Sweden works according to an interdisciplinary, locally approved model by ensuring involvement of all relevant stakeholders including national and local authorities and professional and non-profit organisations.Also, in Norway, the Norwegian Nurses Organisation has contributed on the national level in relation to several consultation responses and participating in national working groups. The inputs have focused on the nurses' role in the AMR work, such as: nurses' contribution to infection control and infection protection is essential to prevent and reduce AMR. In all this context, whatever action we undertake, education is central in the equation of success. In Cyprus, for example, nurses are responsible for training of staff and visitors (e.g. on Universal Precautions), counselling and detection of Potential Outbreaks; and the Infection Control Nurses are involved in policy development of AMR initiatives. Also, a wide range of evidence is available on the content, planning and delivery of nurse prescribing education, which must be considered by the EU and Member States when combatting AMR. The EFN members show clear evidence for the benefits that nurse prescribing can bring for patients, nurses, the wider health service and other health care professionals. The benefits attributed to patients include timely treatment, reduced waiting times and continuity of care. In Ireland, for example, nurses and Midwives have been prescribing since 2008.In Spain, nurse prescribing is regulated through Law 28/2009, of December 30th, and the amendment of Law 29/2006, of July 26th, on guaranties and rational use of medicines and healthcare products. All nurses must be accredited to perform nurse prescribing, both generalist nurses and specialist nurses. The Spanish General Council of Nursing, EFN member, has implemented an education and training process aimed at all nurses throughout the Spanish State that began in September 2010. Currently more than 100.000 Spanish nurses have undergone this education and training process. Looking at these national best practices, there is evidence that nurses are particularly involved in combatting AMR and their role is greatly beneficial to develop 'fit for purpose' policies. Nurses, infection control nurses in particular, link nurses, lead and manage many quality improvement and patient safety programmes across EU member states including those that address AMR and the prevention of infection.

Infection control

Infection control has been a key nursing jurisdiction since the ground-breaking work of Florence Nightingale in the Crimea. Nowadays, Infection Prevention and Control (IPC) Link nurses are an important group in all health and social care settings and across Europe. However, as new and more complex cases of hospital acquired infections occur, there will be greater demand for IPC Link nurses to tackle and control new kinds of bacteria and to stop the spread of infection. The more complex the hospital acquired infection the more IPC Link nurses' time could be needed to monitor and prevent the acquisition and spread of infection throughout an organisation and into other settings. In Cyprus, for example, in each Public Hospital there is at least one Infection Prevention and Control Nurse appointed by the Nursing Management. The nurse collaborates closely with a microbiologist, since much of the infection and epidemiology of recording and control is closely linked to the microbiology laboratory. The IPC nurse is mainly in charge of detection, monitoring and recording of infections and infectious agents (including data on multi drug resistance microbes). Moreover, in Denmark, hygiene nurses are responsible for clinical infections, quality improvement, teaching and guidance, as well as for coordination, interdisciplinary and cross-sectoral cooperation. In Estonia, each hospital has an infection control nurse responsible for complying with a- and antiseptic rules and advancing proposals to improve the situation and ensure patient safety. In Estonia, the national Act "Policies in Place for prescribing antibiotics and infection control requirements in Healthcare settings" is currently being updated, and it will lead to an extent of nurses' rights to prescribe. If nurses can prescribe medicines themselves, they can also have better control and have an overview of the patient's treatment and explain at each stage why one or another medicine is needed, then their over-consumption will be reduced. Additionally, every year Estonia celebrates the international hand washing day, with nurses leading those campaigns all over Estonia.In Finland, healthcare-associated infections are monitored at national level under SIRO – the Finnish Hospital Infection Programme. In its framework, infection control nurses are involved in surveillance of nosocomial bloodstream infections and clostridium difficile infections through laboratory-based case-finding.The EFN believes that it is key to acknowledge the important role of link nurses working in the clinical settings (in the Hospital and community sector) and encourage the recruitment of infection control nurses, as it is crucial to support the multi-disciplinary approach to infection control with teams across a range of settings and professions working together to prevent infection. Also, High Quality of Care and Safety Standards throughout the EU are essential to make progress together with appropriate investment in link nurses and infection control nurses, and in infection prevention and control, emphasising on prevention rather than on a problem-solving approach.

Promoting healthy lives

A focus on prevention is imperative. Still 97% of health budgets are presently spent on treatment, whereas only 3% are invested in prevention. Governments, inter-governmental organisations, non-governmental organisations, civil society, corporations and others must play a major role in supporting the prevention agenda and reducing health inequalities. However, securing the active engagement of citizens, families, carers and communities in making healthier choices and adopting health promoting behaviours is fundamental as is the support necessary to enable healthier options. In day-to-day practice, one of the key ways through which nurses across Europe work actively on prevention is through health education and promotion around such non-communicative diseases as diabetes, Chronic Obstructive Pulmonary Disease (COPD) and coronary heart disease (CHD). Nurses across Europe are active participants in substantial national programmes around prevention such as AIDS prevention, breastfeeding support and even palliative care. For example, in Croatia, nurses have key roles within the Society for Primary Care and Society of Public Health Nurses through which they organise symposia and talks on health promotion. Moreover, the Croatia Nurses Association organise public health actions twice a year to emphasize the importance of nurses in supporting local communities to deal with issues including smoking cessation, obesity, dietary advice, diabetes care, blood pressure control, promotion of health and healthy lifestyle. Similarly, in Estonia, nurses are active participants in national programmes around prevention such as- HIV/AIDS, non-communicative diseases as diabetes and coronary heart disease. In day-to-day practice, nurses in family centres and schools are promoting healthy living by educating people towards balanced diet and exercise and the harmful effects of smoking, alcohol and drugs. In addition, nurses are working closely together with the National Institute for Health Development. Many other countries adopt similar approaches, all capitalising on the close bond that exists between nurses, their patients and local communities. Importantly, the EFN project ENS4Care analysed how nurses and social workers could use technology in a cost-effective way to enhance their practice, empower and educate patients and the public in the prevention of chronic non-communicable diseases (NCDs), and thus healthy life-styles. For example, in Norway, an app has been developed – eRehab – to help in maintaining physical activity following cardiac rehabilitation. The intervention, designed in collaboration with users, has the potential to reduce the number of face-to-face visits and re-hospitalisations, and improve quality of life through increased levels of physical activity. Or the HeartAge Platform based on scientific evidence from the Framingham Heart Study, which provides a simple way of estimating and expressing CVD risk in a way that is easily understandable for the individual citizen. It has been used by more than 6 million people around the world.

Improving access

A key activity through which nurses contribute to the prevention agenda is through increasing access to health and social care services for communities in remote locations and those with mobility requirements. Here, developments in eHealth, especially around virtual coaching,, are becoming increasingly important tools for nurses. For example, in Belgium, a telecare system by Electronic Tabs for nurses and other personnel in Emergency services for thrombosis has been in use since 2014 (created by Brussels Human Robotic Research Center "BruBotics" Vrije Universiteit Brussels VUB). The telecare system is situated in the ambulance, and through using a 4G internet connection patients can be in direct contact with the thrombosis specialist before coming in the hospital. This not only improves quality and efficiency, but also prevents long-term ill health as a result of delayed treatment.In Estonia, qualified family nurses working in areas with low population (eg islands- Kihnu, Ruhnu, small settlements in border areas) are supported through a collaborating platform solution. In areas where the emergency care is led by nurses, they can connect healthcare professions to the platform, where emergency assistance is provided. Digital information, image, sound and video transmission can take place through the system.In Finland, development occurs at multiple levels. Of special note is the development of The Virtual Hospital 2.0 project, which is created in collaboration with all university hospital districts. The project's central outcome is the Terveyskylä.fi ('Health Village') digital health service. It provides information and support for citizens, care for patients and tools for professionals. The service comprises various themed virtual houses, some of which are already open. By the end of 2018, more than 20 houses and services will be available for more than 30 groups of patients. And in the UK, examples of Virtual Coaches include Sense.ly. This offers an avatar-based care approach in the form of a smartphone app and their virtual nurse. This system allows a clinician to monitor a patient's personalised care plan after being discharged from hospital or alternatively the virtual nurse acts as a gatekeeper in a triage system. A patient can check in with their nurse avatar and report symptoms, medications etc. Clinicians can monitor risk factors and adjust clinical protocols accordingly. EFN Members have been capitalising on the opportunities made available by eHealth, innovating in some cases and taking best advantage of technological advances like internet enabled communications. This has been particularly successful in reaching out to rural or isolated areas allowing nurses to reach into patients' homes. Especially for older people or those with long-term conditions this has been vital in maintaining continuity of care. An example from Croatia sees such technology enabling patients on the various islands to have follow-up care, while in Denmark telenursing has been instrumental in supporting individuals with diabetes or chronic pulmonary diseases like COPD,,. eHealth in this context has been especially useful in advancing the work of nurses via enabling direct communication with patients in remote areas via webcam conferencing, exchanging advice between community nurses and more specialised nurses in hospitals, participating in discussions on various patient cases, and even transmitting patient data like x-rays, test results, or wound images.

2.2 Primary Care

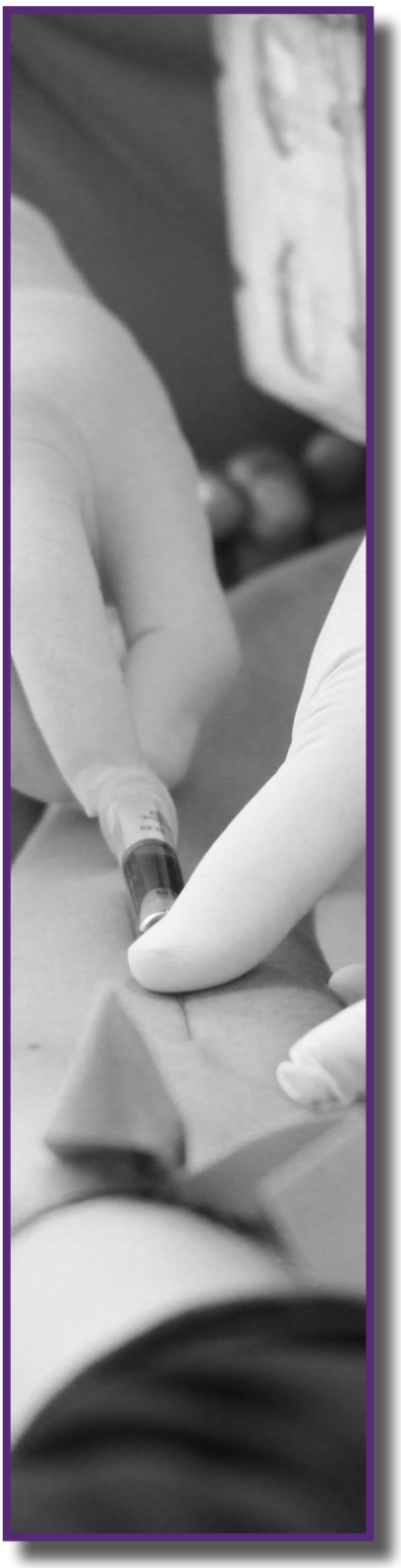
Shifting care delivery away from hospitals and into primary care, settings is integral to many national and EU policies as a means of delivering better and greater people-centred care. Nurses who work in primary care are in many countries the key professionals involved in the management and coordination of complex care for individual patients. Their experience and skills are essential to the success of such policy, yet little is known at EU level about what their work involves, how their roles and responsibilities differ between countries and what are their competencies and needs. Crucially, little is known about how many there are in the EU; what is their demographic, personal and work profiles; and what are their perceptions about the quality and safety of the care provided in community and primary care settings across the EU. Understanding these issues would enable understanding of their needs for delivering patient care, coordinating care pathways within an interprofessional team and making cost-effective use of available eHealth solutions. Primary care nurses, members of EFN, are actively working on key project areas including: interprofessional collaboration, chronic conditions, pain management, use of eHealth and electronic health records.,, Among these examples the global philosophy is noted to be the development of complementary services and roles; and promoting a collaborative and cooperative spirit between health professionals towards delivering a better patient/citizen experience. In the UK, for example, the Cuckoo Lane Practice serves more than 5,500 patients. It is one of the few practices in the UK to be nurse-led, rather than run by GPs. Not only is the practice run by two nurses, most of the appointments are carried out by nurses too. These nurses have received extra training, so they can do most of the work normally done by GPs, such as prescribing medication. Also, the Queen's Nursing Institute promotes community nursing specifically to nurses, employers, educators and policy makers. They have highlighted the complexity and high quality of nursing provided by district nurses working in the community.

Family nursing

In some countries – e.g. Belgium, Portugal – developments in primary care have been supported by national policy with significant nursing input. For example, in Belgium a regional decree has been in place since 1987 that organizes and finances an interprofessional approach to Home Care. This enables the coordination of the Family Physician, Family Home Care Nurse, Pharmacist, Physiotherapist and Social worker. In Estonia, the majority of family physicians have two family nurses for one practice. A patient needing care is usually sent to a nurse's appointment and, in cooperation with the patient, a decision is made whether the medical condition also requires the attention of a doctor. This is an example of nurses leading the process. Furthermore, nationwide system of health centres is currently being developed in Estonia, which will bring the home and family nurses together. This will simplify the work of the teams in primary care centres and will raise the quality of nursing care. The number of ambulatory nurses' appointments is also rising every year. This means that more and more people who are suffering from chronic diseases trust nurses.Moreover, in Portugal, the role of the Family Nurse (a specialist nurse in Family Nursing) has been developed. Family nurses act as the professionals who, integrated in a multidisciplinary team, are in charge of the global nursing care tendered to families in all life stages and community contexts.

New nursing roles

Success in primary care in many countries has been boosted by the development of new nursing roles, with nurses taking on a more active leadership approach to the provision of primary care – e.g. Denmark, Estonia, Finland, Portugal, UK. In Denmark, for example, the most vulnerable chronically ill patients are offered the support of a specially trained nurse in their community who can guide them through the health system with active and individual support to manage their disease. For a period of 6-9 months chronically ill patients have the option of telephone support from a specially trained nurse who gives them personal advice; the nurse also works in close collaboration with patients' doctors. Estonia is currently undertaking an amendment of two laws and six regulations to give nurses new roles and bigger responsibilities. The process is expected to be completed by the end of 2019.Similarly, in Finland, new roles for nurses have been developed to reallocate certain patient groups with acute health problems and non-communicable diseases from a physician's care to a nurse's care. Nurses consult within the interprofessional team or work in pairs with physicians in health centres and emergency care units. Moreover, nurses take on roles as case managers, which includes coordinating care and resources and managing caseloads. Certain responsibilities are redistributed between nurses and doctors, and nurse prescribing is applied according to legislative requirements. In the UK, a number of nurses working in primary care settings are starting to take on key leadership positions for example with becoming Nurse Partners in GP practices, with some practices now managed entirely by nurses.Another example from Germany refers to the implementation of a new role of Family Health Nurses in primary care, with a focus on supporting and counselling families who care for an older frail member of the family. Moreover, in Greece, nurses are expanding their practice through piloting the application and development of 12 protocols of nursing diagnosis/ plans of care dealing with health problems specific to Primary Health Care; and 36 protocols referring to Home Care. Finally, in Denmark nurses trained as children health-visitors offer home visits in the first years in new families, health screenings and examinations for school pupils, courses for adults and counselling for employees in day-care, schools etc. Reports from Denmark show they have great impact when it comes to prevention, healthy lifestyle, smoking cessation, alcohol prevention, wellbeing and mental health. In Denmark their important role is acknowledged, and their numbers have risen with 120 such nurses trained every year.



Advanced Nurse Practitioners

An increasingly important development within primary care concerns Advanced Nurse Practitioners (ANPs). These roles are not unique within primary care, but their utilisation in this setting is growing rapidly. Most EU countries now have ANPs working within their health and social care ecosystem, although this category of nurses is not consistently recognised or regulated. To date, only a few countries such as Finland, Ireland and the Netherlands have put in place clear regulatory and practice frameworks for ANPs.

In Finland, for example, the general main tasks of nurses with advanced diploma or degree are (Post-graduate diploma = 30-60 ECTS i.e. about 750 to 1500 hours or Master's level = 60-90 ECTS i.e. about 1500 to 2250 hours):

- advanced nurse consultation and diagnosis (advanced physiological and psychological assessment)
- ordering and carrying out diagnostic tests (echography)
- management of a range of chronic diseases (follow-up, monitoring, health education and lifestyle advice for non-acute cases)
- management of a range of acute health problems (examination of patient´s symptoms and assessment of care needs in minor infections and injuries)
- developing evidence based clinical practice in collaboration with other stakeholders by e.g. different development projects, education, consultation, interprofessional collaboration, as well as research and publishing activities.

In addition, nurses do have extended roles in rural and remote areas. For example, Finland has nursing reception facilities in smaller health stations which are supported by e-consultations with doctors if necessary, with only 22% of the patients sent by the nurses to the main health station to be seen by a physician.In the Netherlands, ANPs are regulated by law since 2009 and practice in all medical fields. The requirements are: Bachelor's degree in nursing, been registered, at least two years working experience, working contract for at least 32 Hours (ANP workplace and mentor available in workplace), excellent Dutch speaking and best English skills for reading literature. ANPs are trained at: clinical act, leadership, knowledge and research. The nurse practitioner is the link between the doctor and the nurse. In a lot of fields, the ANPs have their own patients and can prescribe medication. They

improve the quality of patient care and have a coordinating role task. The nurse practitioner is much cheaper than a doctor and just a little bit more expensive than a nurse.

So, it is pretty cost effective. It is a nurse doing the job of a doctor.But this is being put in place step by step. Most EFN Members report to have set up in their countries postgraduate education programmes for registered nurses to advance their career into ANP roles. Universities around Europe have therefore developed new curricula for ANP Master degrees. The competencies acquired through this training include: leadership and consultancy skills, people-centred care, autonomous practice and decision-making, collaborative working, chronic disease management, expert clinical knowledge and commitment to education, research and development.

For example, both of the health care colleges in Estonia started a new curriculum of Master's studies for Advanced Nurse Practitioner's in September 2018. Until now, nurses have followed the Master's programme in nursing pedagogy and management in Tartu University, but there has been an increase in the demand for studies focusing more on practical qualifications of nurses, which give them the opportunity to continue their studies in doctoral (PhD) programme. The new curriculum has four options: health nursing, intensive care nursing, clinical nursing, mental health nursing. The new curriculum is 90 ECTS.Some ANPs can also have extended roles with legally defined activities, such as prescribing and ePrescribing. However, ANPs are still considered an evolving role and many nurses operating at this level are still treated as specialist nurses. Evidence for the cost-benefit of ANPs is mounting, with some EFN Members such as the Royal College of Nursing in the UK supporting research projects on the benefits of having ANPs within the health and social care system.

Nurse ePrescribing

One of the most promising developments within, although not exclusively in, primary care is nurse prescribing. Evidence from countries that have already adopted this show that health and social care systems with nurse prescribers are more cost-effective and patients get faster access to treatment. Those early adopters are now well-prepared to take on the next step and are giving up prescribing on paper formulas to start ePrescribing. Through nurse ePrescribing, patient and drug safety can be improved, and the prescribing and dispensing of medicines can be done faster, easier and more efficient thus reducing pressure on physicians and the wider primary care system. The process across EFN Members is still at an early stage and to date only a few countries such as Estonia, Finland, Ireland, the Netherlands, Sweden, Spain and the UK have implemented or started the implementation process for nurse prescribing. In Estonia, since March 2016, family nurses have the right to prescribe a prescription medicine for continued treatment. Only family nurses who have completed the 120-hours continuing education in clinical pharmacology at the University of Tartu have the right to prescribe to continue the care provided by a family doctor. Nurses have limited prescribing rights, and nowadays this right is owned by about 120 family nurses. Interestingly, in Estonia only digital prescribing is being used, with 98% prescribing digital.In Ireland, primary legislation for nurse and midwife medicinal product prescribing was introduced early in 2006. Nurses and midwives in Ireland have been prescribing since 2008. In Ireland, all nurses and midwives can undertake prescribing once they undertake an education programme and meet certain conditions. There are now more than 450 nurses and midwives with prescriptive authority employed in the public health services. The candidates going through the education programme to become Registered Nurse Prescribers (RNPs) come from 86 different clinical areas and 165 health service providers (49 acute hospitals and 116 primary and community services) across Ireland.In Spain, all nurses need to be accredited to prescribe, but they can autonomously prescribe all drugs not subject to medical prescribing & all healthcare products; Collaboratively prescribe drugs subject to medical prescribing through guidelines and protocols devised jointly by the Ministry of Health and the regulatory bodies of physicians and nurses.The EFN EU project ENS4Care, recognises that nurse ePrescribing programme development within the EU (in as far as is possible) should start from the premise that it shall be part of an enterprise national or regional deployment programme for Electronic Health Record (EHR). Recognition that integrated models of care are required to tackle fragmentation of healthcare services provision is a first principle. ePrescribing in Europe is a dynamic activity which is shaped by a number of key facilitators and barriers.

2.3 Integrated Care

EFN Members are active supporters for the development of more integrated care models across Europe. Adopting cost-effective integrated care models can assist Member States in giving their health systems the needed boost to advance. From a nursing perspective, such models help push forward coordination between primary and secondary care; and between health, social and community care, while retaining focus on the individual patient. It is time to invest in health, innovate the future, and inspire progress!

Integration for quality care

A key outcome of a truly integrated system is the improvement in the quality of care for patients and their family members. One example of how this is realised comes from Ireland, where a Quality and Clinical Care Directorate was established in 2010 to help improve the patient journey through the health system. Twenty integrated patient care programmes were established under the leadership of a multidisciplinary team of clinical professionals including clinical nurse specialists, general practitioners, consultants and allied healthcare professionals. Such programmes focus on improving care, significantly reducing waiting times, cutting out inefficiencies and being cost effective. Integrated care programmes include such areas as heart failure, stroke, acute coronary syndrome, COPD, asthma, rheumatology, primary care, epilepsy, care of the elderly and emergency medicine. Clinical nurse specialists and ANPs in these programmes work within a multidisciplinary team and play a lead role in rolling out these programmes. In Estonia, in cooperation with the programme Cognuse, certain nursing codes have already been digitized and the work continues. The goal is to add the most important nursing activities into the app so that the nurse can check the correctness of the activities performed before or parallel to the procedure.In Czech Republic, for example, the insurance companies started to reimburse "a remote monitoring of patients with schizophrenia", within the scope of a preventative programme "ITAREPS" monitoring alerting symptoms of these patients. The symptoms are reported to the physician and an early intervention prevents re-hospitalisation. In Greece, a non-profit organisation called "MERIMNA" provides integrated care models in children with chronic diseases (cancer) in home settings. This organisation is not led by a nurse but by an administrative board in which there is a nurse. Nurses have a very important role at organisational level and for providing integrated care models in children with cancer and coordinating between primary and secondary care. The company was founded in 1995 by nine experienced scientists from the wider field of health and education, who work on interdisciplinary implementation of the objectives of Welfare. Another example is in Portugal, where the Community Health Care Unity (a formal unit, created by governmental law, with a formal contract comprising a package of health services to be delivered and with indicators of quality to be achieved, and led by a specialist nurse and is constituted by a multidisciplinary group (dentists, nurses, physicians, physiotherapists, psychologists and support staff)) provides, ensures and increases the access to health and social care to the population in their communities, especially those that are considered most frail or at risk. In Spain, after a law on nurse prescribing was approved, a platform was put in place to support this new role for nurses. Moreover, a course is being provided for free for nurses (for nurse prescribing purposes), they must acquire a license to utilise the IT platform and the Ministry of Health is in charge of accreditation.

eHealth

A key enabler for integrated care is the development of eHealth solutions. EFN Members see clearly that eHealth has enormous potential in enabling continuity of care, especially for individuals with long-term conditions, leading to an optimised and more efficient healthcare service. Several examples of successful eHealth enabled integrated care systems are noted by the EFN Members, such as from Belgium, Estonia, Finland and Norway. Estonia has decided to start using digital NANDA, NIC and NOC classification. Nurses are currently using the nursing diagnoses and they are applying for a translation license to NIC and NOC. For five years, this diagnostic system has been taught in Estonian health care colleges. An example from Norway is of a project that focused on the development of standard nursing care plans for nursing homes and homecare nursing based on the International Classification for Nursing Practice, which will be integrated in an electronic health record. Additionally, eHealth has enormous potentials in fostering integrated communication and collaboration between the healthcare team with implications for safety, quality, and efficiency. Such examples include Norway's "Te@mwork" project along with the Norway Nurses Organisation strategy "Nurses' contribution to Te@mwork through e-cooperation". In Spain, the General Council of Nursing (EFN Member), developed a digital platform "e-cuidados" ('e-care') with the main objective "To protect the health of people and guarantee the patients' safety through an ethical, autonomous and competent professional nurse practice". To do this, it provides nurses with a lot of information that allows an adequate management of nursing knowledge, facilitating clinical practice, with safety guarantees for patients and professionals. Knowledge management is based on the incorporation of powerful databases to allow the constant updating of knowledge by nurses regarding nursing languages and work methodology. Regarding the nursing language, it must be remembered that the new Directive 2013/55/EU includes the nurse competence to independently diagnose the using theoretical and clinical knowledge. Therefore, the e-care platform provides a clear answer to the need incorporated in this Directive, since it includes, among the nursing language, the one referred to the Nursing Diagnosis, which allows nurses to identify the best nursing care needed by patients. In addition, the platform offers standardized nurse care practice guides and protocols which ensure a high-quality healthcare practice based on scientific evidence and with a real vision for its application in clinical practice. This is helpful to "ensure that the necessary requirements in terms of quality, safety and efficiency are guaranteed in cross-border healthcare" (one of the objectives of Directive 2011/24/EU on cross-border healthcare). Besides, the platform provides safety elements for pharmaco surveillance, responding to the provisions of Directive 2010/84/EU.In 2016 the Swedish government took a National vision for eHealth. During the following years, Sweden has gone through a transformation regarding information between care providing organisations, digital alarms, digital documentation and time-planning systems. But there is still need for improvement regarding using digital technology in delivering individual care to patients in long term care.Some examples of e-health used in LTC in Sweden relate to the feeding robot (independent eating - patient control amount and pace of feeding - patient use remote control - invented by patient who was "fed up" by not being in charge of eating); the sensor technology for individualised incontinence care, and innovative technology to provide evidence-based continence planning: digitally tracks voiding patterns as they occur over 72 hrs and graphically converts the data into actionable, evidence-based reports to help effectively optimize individualized continence care in terms of: improved quality of life, optimized toilet routines, minimized time spent on manual assessments, and optimized products selection. Another example is the Digital Technology in home care to reduce travel and increase quality in care at the same time, based on co-designing digital services and end-users choosing services, focussing on the cooperation between health professionals and patients. Another example is filling pillbox and medicine reminders, with sometimes reminder-devices being called medication robots. The remote stethoscope, a distance technology to avoid traveling and remote auscultations of heart and lung sounds, with the nurse examining and using the electronic stethoscope and the doctor hearing the sounds from the stethoscope and participate in the examination from the remote location. The Kol-webben, the COPD WEB site is a Web platform providing information and care advice related chronic obstructive pulmonary disease COPD, for health professionals, patients and family. Tree municipals, two Universities and some companies are involved in the project

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The main issue with the project is to secure a safe and smart home environment. That involve alarm systems on the electric meter, the water meter, and different movement sensors. By measuring the persons "normal" consumption and movements the system will read abnormalities and call on attention by a text message to significant others or health professionals. Furthermore, The Hearth echography-robot is placed in the health centre in the right position on the patient. A nurse or a physician are doing the examination on line. The patient doesn't need to travel to a hospital and will get the result straight away. Finally, in the UK, the Royal College of Nursing has produced jointly with Health Education England a publication on Improving Digital Literacy for staff in the health and social care workforce. It defines the digital capabilities nurses need that can also be mapped to the nursing regulators code – the Nursing and Midwifery Council.

The EFN ENS4Care project pointed out in its Guidelines on Integrated Care that safe and high-quality care is inextricably linked with the development and implementation of eHealth services. Whilst nurses, social workers and other care staff across Europe already possess well-developed core skills and shared values, there are significant variations in the organisation and management of services and the roles that health and social care staff undertake in different countries.

Integrated care along the care continuum is essential to ensuring optimal outcomes are achieved for all people living in the EU, especially those burdened with chronic disease and complex care needs and who require attention from a range of professionals from primary and secondary health and social care sectors. eHealth is a key enabler for integrated care, used here to refer to the management and delivery of health and social care services so that citizens receive a continuum of preventive, curative and supporting services, according to their needs over time and across different levels of the health and social care systems. eHealth plays a key role in supporting the introduction and development of the new skills required to deploy integrated care.

People-centred services

Integrated care should not just be about efficiency of services and cost-savings, but should be developed in response to a clear patient need. While wider system integration is important, EFN Members also report smaller scale examples improving care for particular patient groups and conditions. In Germany, one example is the implementation of a coordinated approach combining all health professionals and health institutions in one city in Northern Germany towards pain management. The project is titled 'Pain free city Muenster' and is led by a nurse researcher. Moreover, in Norway, one initiative to address the rise in the proportion of people with chronic conditions required all municipalities to establish supplemented care known as 'municipal emergency beds'. Some of these can be compared to community hospitals and others may involve one or two beds located in a nursing home supervised by nurses. In Denmark, the Health Ministry has developed a strategy for digitalisation 2018-2022. The focus is to ensure that care is coherent and close to the patient. This is a response to the demographic development and the increased need for LTC. Additionally, in Denmark there is a strong focus on telehealth, used for patients with chronic diseases, especially COPD-patients, in the treatment of chronic wounds and physical training. Telehealth allows the patients to remain at home and it prevents hospitalisation. Furthermore, electronic patient records and electronic overview of the patient's medication are an established practice in Denmark, which ensures easy access to patient data for both the patient and the health professionals.Finally, in Denmark, the Danish Country Health Profile 2017 showed that smoking declined sharply but excessive alcohol consumption by adults and particularly by adolescents was the highest in the EU. Consequently, effort is invested at supporting an integrated system with more advanced nurses to further enhance efficiency in the health system and tackle this challenge.

2.4 Resilient workforce

Safe and quality healthcare cannot be achieved unless the health professional workforce itself is of high quality and operates within safe conditions. The EFN Members have always known this and actively lobbied for policies that support development of a resilient workforce.

Workforce data

Health policies for a resilient workforce rely on accurate workforce data. The categories for the nursing profession currently used in the OECD-WHO-Eurostat Joint Questionnaire to collect data at national level are based on the ISCO-08 code. However, using the ISCO 08-code for nursing care will lead to inaccurate data collection, inappropriate comparison of the nursing workforce and, finally, to unrealistic planning for the future. The EFN therefore argues that the ISCO-08 code is mismatching occupations and qualifications, creating confusion on the terminology and leading to unreliable data collection to plan and forecast the EU health workforce.To have a coherent approach of workforce planning and forecasting methodologies across the different EU-led initiatives, the EFN positioned to advocate for 3+1 categories in nursing care, in line with international developments. These categories provide clarity to enable collection of comparable data for planning and forecasting, and also provide clarity on the European skills/competencies, qualifications and occupations for future health workforce developments.Within a context of growing and changing healthcare needs, health system reform, and new and more exigent requirements of care, a broader understanding of the different roles and professional categories in the nursing care is needed, next to having a clear picture of the exact and comparable numbers of the entire nursing workforce. This is the reason why the EFN has been working to get valid, reliable and professional relevant data upon which best nursing workforce policies can be developed at national level, based on the support given by EU and International Organisations.

The Nursing Workforce in a changing ecosystem

Ageing population, longer life expectancy, increasing and more complex chronic diseases represent the main challenges for the health and social care systems of the future. Within this context, a resilient and motivated workforce is a crucial element to deliver high-quality health and social care services and improve the quality of life for long-term care (LTC) patients.

When it comes to LTC, the availability of nurses is a crucial determinant for the ecosystem well-functioning, also considering that a large proportion of LTC in the EU is provided by informal carers such as family members and friends, while the formal care workforce is often associated with unqualified frontline, very low recognition and salaries, which leads to relatively high staff turnover and staff shortages in most countries. It is extremely difficult to recruit and retain an LTC workforce to deliver care. As emerged from the EFN Members input, in most countries, due to the ageing population, an increasing need of long-term care staff emerges. However, the type of workforce and settings involved in the provision of LTC services varies across Europe.

For instance, in Croatia, institutional care for the elderly involves long-term care in social welfare homes or other legal entities. Out-of-institutional care for the elderly includes home support in the user's home, long-term family home accommodation, organized accommodation, and foster families. In parallel, in Denmark, due to the Danish family structures, and the development in the labour market (retention), LTC will mainly be formal care (not informal caregivers e.g. family). Likewise, Norway and the Netherlands are facing a shortage of nurses in primary care/municipal care. The latter has developed an approach of the staff shortages in the elderly care sector, including agreements on job security, training opportunities, attracting new personnel and the deployment of technology.

The education level of LTC nurses in the countries analysed varies significantly as the type of nursing practitioner involved in the provision of LTC services is often associated with the high shortage of nurses in the country. For instance, in Denmark, as in many other countries, there is a lack of nurses. The estimated number is a need of 6000 extra nurses by 2025. In addition, there is a need for higher competency developments in the primary care settings, as the health and social care ecosystem is moving into people's homes, and there is a need for more complex knowledge and competencies. In fact, in Denmark, LTC is mainly provided in the primary care setting. In this context, the Danish Nurses Association (DNO) has succeeded in promoting a strategy of a "double lift" in competencies, with two new education programmes:

A specialised education for nurses in the primary care. The first students began in December 2018.An advanced practice nurses in primary care. It will be a 2-year master's degree (120 ETCS) with a strong clinical focus. The first students will begin in September 2019.

The Netherlands has observed that new professional profiles are needed to be able to continue to deliver high quality care. The future care requires to look at different components: the patient is empowering, new techniques are emerging, and the care that patients need is becoming increasingly complex. To meet these demanding changes, there is a need for different, well equipped professionals, who deliver efficient, safe and qualitative save care. In this context, for the first time a distinction is going to be made between nurses who are educated the intermediate vocational education level and the higher bachelor level.In parallel, in Germany, the demand of long-term care at home and in nursing homes nursing services have expanded in the last year, due to demographic changes and the establishment of a special branch of social security system to cover expenditure in case of long-term care is required. This rising demand is confronted with a shortage of nurses nationwide. Currently approx. 170,000 nurses (general nurses, geriatric nurses and paediatric nurses) work in ambulatory nursing services and 225,000 in nursing homes. In nursing homes staffing ratios are defined by regional legislation, with 50% of nursing staff required to have a minimum of 3 years education (Directive 2013/55/EU). It is important to observe that more than 85% of employees in LTC are female, and the majority of nurses' work part time. Additionally, salaries in long term care are much lower than those in hospitals, which is a he problem for recruitment and retention. In Italy, nurses are involved in the regional projects on long-term care. Sometimes these nurses have an education at post-graduate diploma level (in Italy denominated as first level master's degree). However, most of them take this role because of their experience and do not have specific education. There are also a lot of formal caregiver (that are not nurses and not relatives) that work generally in patient's home or as a support operator in LTC units. Homogeneous standards are not available at the moment in the country: in some cases (depending on the Regions), nurses are involved in LTC work as "freelance professionals" and there is a lack of established standards in the field. In other cases (always depending on the Regions) nurses are involved in specific programs that are led by the Health System. In these cases, they do not work as "freelance professionals" and refer to specific organizational models.

From these experiences, it becomes clear that the LTC Workforce needs specific attention, especially when it comes to the design of the nursing competencies, the strategies to attract and retain nurses to the LTC sectors, focussing on the salaries and working conditions to stay in LTC. More nurses are needed in LTC to address the unmet needs of patients

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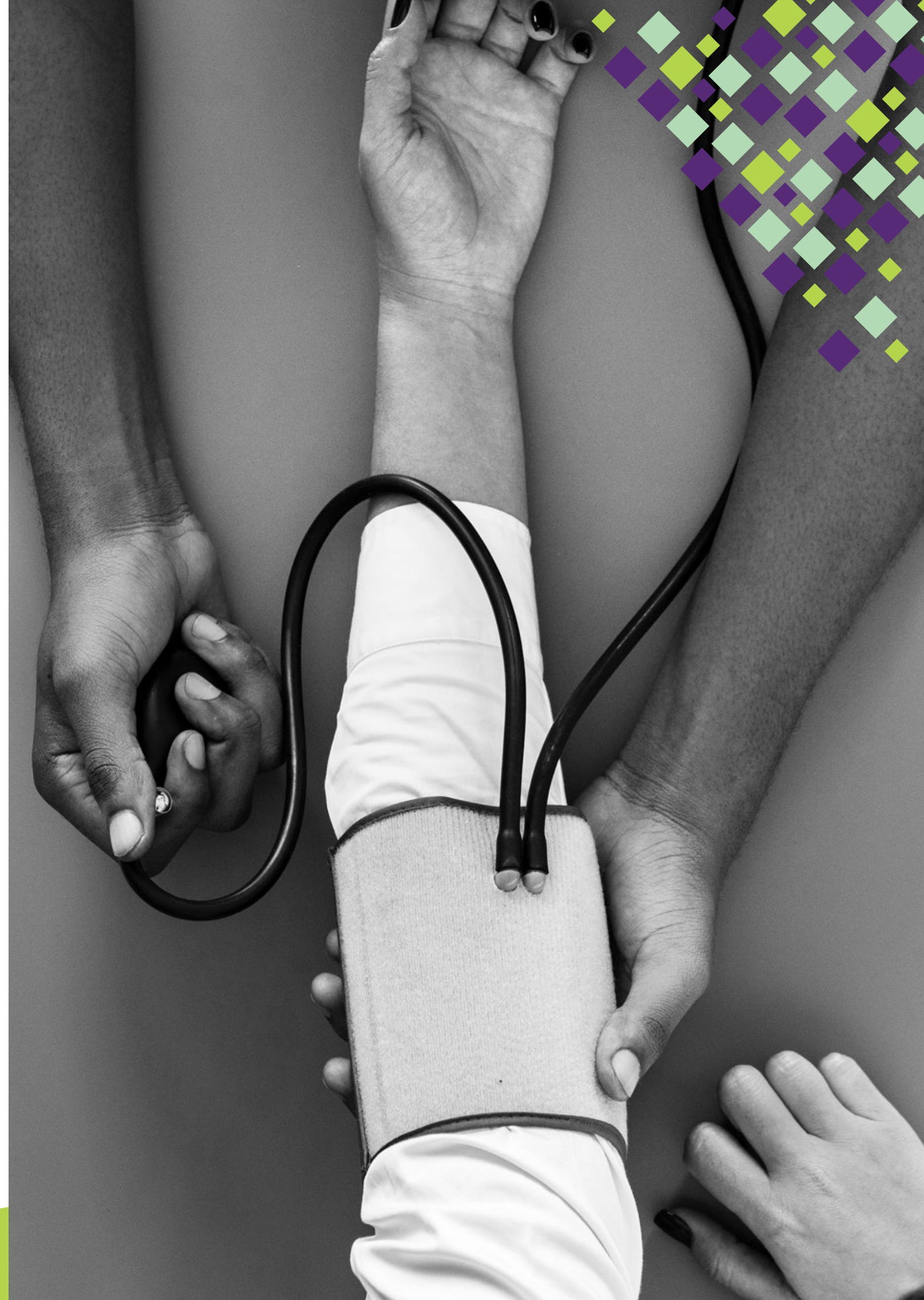

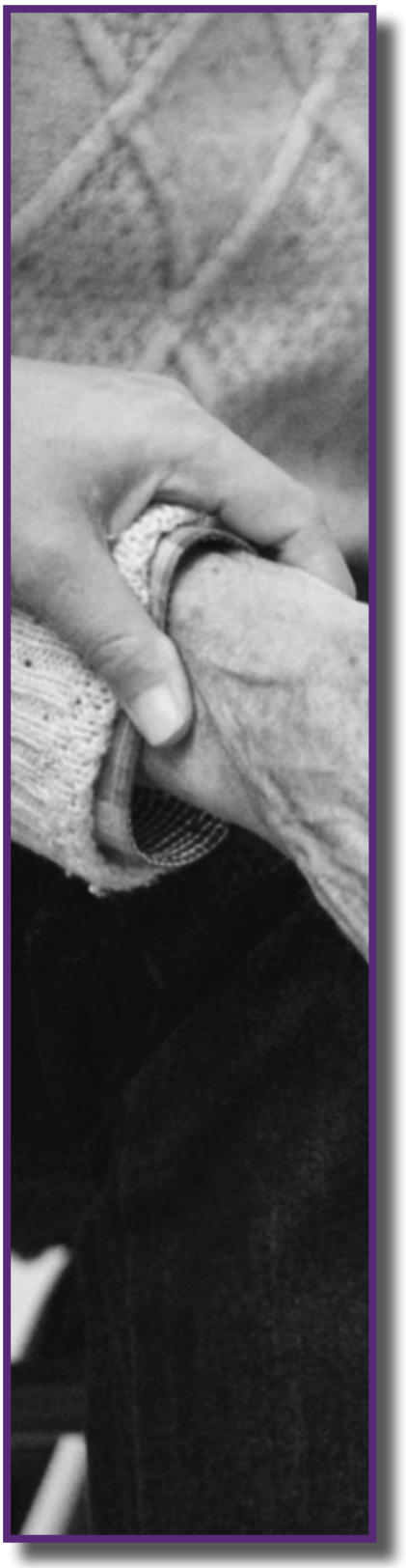

2008 financial crisis effects

The nursing workforce in Europe has been hit hard by the global financial challenges of recent years and the effects are still felt strongly. Since the onset of the global financial crisis in early 2008 the EFN Members have observed the effects on nurses and nursing with watchful vigilance. The effects are obvious: an actual reduction in nurses' posts across Europe, nurses' pay cuts and salary freezes, diminished recruitment and retention rates, and observed compromises in quality of care and patient safety. In particular: over half of EFN members report pay cuts, pay freeze and rising unemployment for nurses; over a third of EFN members report concerns about quality of care and patient safety; over one fifth of EFN members report downgrading of nursing and substitution of nurses with unskilled workers. Effectively, this has resulted in nurses all over Europe to work harder than before to maintain quality standards, while being asked to provide more for less. As nursing is a primarily female dominated profession, women in the EU are unequally and hardest hit.

Follow up reports reveal the significant impacts of those short-sighted interventions on the shape of the profession today. Posts for nurses have been reduced and recruitment efforts have decreased. Attention is now on retention strategies trying to keep nurses where they are needed most, despite not offering the best working conditions. A common denominator is salary cuts, making the profession unattractive. The implemented material reduction measures in several countries are expected to lead to increases in healthcare associated infections and other complications affecting the quality and safety of care. In terms of quality and safety, nurses have expressed that under conditions of extreme workforce shortage patient safety is jeopardised. The increase in the number of work hours compromises nurses' wellbeing with implications for the quality of care they deliver. There is a clear link between quality working conditions for the health workforce that consequently lead to an improvement in terms of quality and safety. More investment on resolving these problems should be given priority by the EU institutions, keeping safe nurse-patient ratios.

It is time that policy and decision makers to take this issue seriously and start taking steps forward and implement measures to keep patient safety and quality of care high on their agenda. Nurses are the largest occupational group in the health sector, providing frontline care, 24 hours/7 days in a roll, 365 days a year. Therefore, when redesigning health and social care ecosystems at local, national & EU levels, it is critical to foster nurses' views and solutions to strengthen integrated care and workforce development.

Continued Professional Development

The demand from consumers, service providers and educators for highly-skilled nurses who can respond to and influence changing needs and practice demands has occurred within a political change in health system reform debated in different European and international institutions. In the context of quality of care and patient safety in Europe, it is imperative that all nurses become active participants in the development of knowledge and practice. It is very important that the nurse has the individual responsibility to be accountable and able to lead quality improvement initiatives. As a profession, nurses have always been engaged in continuing professional development (CPD). The need for nurses to maintain and update their knowledge and skills is seen as essential for achieving and maintaining quality in service provision. This is in keeping with a broader recognition that lifelong learning, embracing both formal and informal post-basic education, is an ongoing requirement for all nurses. However, developments in CPD are not consistent across EU countries and there remains a lack of investment in this area. In response to financial challenges a number of countries are cutting down education budgets for nurses, which risks leaving nurses out of date with recent developments. This trend needs to be reversed to safeguard the quality and resilience of the nursing workforce, and ensure quality and safety of healthcare.

Mutual recognition

The EFN Members have always maintained that the EU Directive 2013/55/EU on the mutual recognition of professional qualifications, has been a tremendous success in ensuring free movement of nurses within the EU. Nurses, as the single largest health professional group, account for the majority of movement within the EU and the Directive has made such nurse mobility possible. The EFN Members from Cyprus, Spain, Ireland, Iceland, and the UK among others support that the Directive's automatic recognition procedure in case of migration has resulted in considerably facilitating and expediting recognition and registration of nurses.The Directive although clearly addressing issues of internal market has also had a substantial impact on advancing the profession of nursing and the status of nurses and women across Europe. For example, the Norwegian Nurses Organisation reported how the Directive enabled the positioning of nursing education in the Higher Education degree structure. Previously, in Norway, clinical practice did not count as academic study, but has gained this status through the Directive. A similar example comes from the Czech Republic where after transposition of the Directive into national legislation nurse education has moved into Universities and Colleges. Moreover, to countries such as Croatia and FYR Macedonia the Directive has been the cornerstone of massive educational reform raising the quality bar of nurse education. Considering how the largest proportion of the nursing workforce is female, upgrading the education and status of nurses is steadily impacting on balancing gender inequalities within the EU and Europe. The Directive therefore is also seen as indirectly having a human rights dimension.

It has been well known within the nursing community that quality nurse education is linked with improved patient outcomes and reduction in patient safety incidents. The minimum requirements as set out in the Directive are therefore considered as a benchmark ensuring quality nurse education and a quality nursing workforce able to deliver safe patient care. Furthermore, EFN Members including from Germany, Netherlands and Sweden argue how the minimum training requirements have proven to be a valuable safeguard to quality and safety in healthcare since they discourage governments from downgrading nurse education requirements as means of reducing costs. The Directive is therefore seen not only as a success in achieving its primary purpose of supporting the EU internal market, but also as having important positive implications for the profession of nursing as well as for the safety and wellbeing of EU patients.

2.5 Big data

Excessive data collection is often seen as a hindrance to the delivery of quality nursing care, but the value of carefully considered patient data remains undisputed. The EFN supports the Commission's message of ensuring the collection of better but not necessarily more data., Much of the data collection taking place at hospitals across Europe has little practical application to patient and nursing care because it is not always patient-centred in approach. Patient reported outcome and experience data need to replace current data collection practices in order to start using data to make improvements to things that actually matter to patients.

Data and quality measurement

Quality measurement and data collection are particularly challenging, especially in LTC due to degenerative nature and the multiple care settings involved in its provision. More effective monitoring of long-term care quality, and the development of robust, comparable measures, is still a challenge for many EU governments. In this sense, the EFN Members encourage the use of reliable and valid data indicators to monitor and evaluate the accessibility, affordability, quality, and impact of LTC services.

Nursing-Sensitive Indicators (NSIs) are measures and indicators that reflect the structure (supply of nursing staff, skill level and education of the LTC team), processes (assessment, intervention, and job satisfaction) and outcomes (patient outcomes that improve if there are higher quantity and quality of nursing care). They are distinct and specific to nursing and differ from medical indicators which are not linked to the care quality. Indicators that quantify nursing contribution to healthcare are required to: provide a relevant, accurate and comprehensive illustration of the nursing contribution and demonstrate the value and benefit of nursing services in line with stated standards, domains of practice and objectives. Quality measurement systems for LTC differ among European countries.

In Denmark, a national programme of quality in health care include eight national goals for the health system with corresponding indicators. The indicators are measured every year and is the basis of an annual status-report. Several of the goals are directly or indirectly related to LTC. For example, one goal is to strengthen the care and treatment for the chronic and elderly patients. There has been measured a positive development on the majority of the indicators in 2017. Currently the municipalities focus on how to ensure that the measured indicators cover all the important aspects.

In Croatia, the application of the Programme four levels of geriatric health care in homes for the elderly is an efficient way to meet the health needs and functional abilities of geriatric patients. The application of these four levels is carried out with a team of general/family medicine specialists with appropriate number of nurses and other health care professionals and provides health care according to the individual needs of the users. Additionally, in Croatia nursing documentation is a set of data that serves the quality control of planned and implemented geriatric health care and is intended for use in everyday practice in institutional and non- institutional care for the elderly. Nurses have always evaluated the condition of patients and based on these assessments the nursing care pathways has be adjusted.

Similarly, in Sweden a national quality register has been developed – Senior Alert. This register aims to ensure a preventative approach within the areas of: cases of falls; ulcers/pressure sores; malnutrition; poor oral health; bladder dysfunction/incontinence. Senior Alert action aims at creating an added value for all professionals and organizations in the field of health and social care, supporting them in risk assessments, actions taken, and improvements built on data from the register in daily life. The four most important features are: registration in the quality register; preventative approaches; reflecting on the outcomes; and improvements.

In Norway, the directorate for Health oversees a national program for health care quality indicators. These quality indicators include LTC, and the program is under continues development – new indicators are launched regularly. The program includes results from national patient experience surveys, as well as quality indicators for different criteria, i.e. death rates, infection rates. Additionally, the Patients' rights Act regulates citizen's and resident's rights to quality care. The health care personnel Act defines health care personnel's duties and responsibilities, and health care personnel's rights to organise the work and environment to enable the provision of quality care. The health care acts have regulations to ensure quality and dignity in health care.

In parallel, in the Netherlands, the University Medical Centre Groningen (Groningen), Radboud University Medical Centre (Radboud UMC - Nijmegen) and Rijnstate hospital (Arnhem) are working with measures to reducing the administrative/registration burden. In the ZIRE experiment (ZIRE = Zinvolle Registratie (English: Useful Registration) hospitals are limiting registrations to a set of meaningful quality indicators, that can be used for quality improvements and relevant to patients. Reducing the administrative regulatory burden aims to ensure that health care providers spend more time with their patients. These incentives of reducing administrative burden are also found in other areas of the Dutch healthcare (especially long-term care for elderly and the mental health care).

As far as concerns the Italian system, there are not specific nursing quality indicators for LTC. These quality indicators are collected in the general Italian health outcomes evaluation. As reported in the European Semester Country Reports 2018, health outcomes are generally above the EU average.Finally, in Switzerland, residents in nursing homes often have severe cognitive and/or physical limitations and several chronic illnesses. Their treatment and care are complex, they require interprofessional cooperation as well as in-depth geriatric knowledge and the skills of all actors involved. A research team at the University of Basel is currently developing a nursing-directed care model to reduce avoidable hospitalizations from nursing homes and to improve the quality of care. More effective monitoring of long-term care quality, and the development of robust, comparable measures, should be a priority for EU governments. In this sense, the EFN Members encourage the use of reliable and valid data indicators to monitor and evaluate the accessibility, affordability, quality, and impact of LTC services. Investing in social and health outcomes, and more robust social and health outcomes measurement, including patient experience and nursing-sensitive data are crucial to create a real value for patients in LTC. Therefore, a shift is needed from a fragmented system in which patients struggle with access and in finding their way in the system – especially for patients suffering from multi-morbidities that need to interact multiple times with the system – towards a patient, citizen and people-centred model that empowers the individual.

Data sharing

Further to better data collection, it is important to ensure improved ways of sharing and using patient data. Citizen and patient' trust is a central concept in developing digital tools requiring data sharing, therefore, patients and health professionals are central in the data sharing governance. In this context, due to the close relation the nurses develop with the patients and their families, and in their coaching roles, frontline is ideally placed to reinforce the existing trust from citizens towards eHealth solutions.

In Belgium, for example, eHealth exchanges of patients' files and data have been in place since 2012. This is through an Electronic Network between Hospital physicians/ services and home care/ family physicians. The same electronic exchange structure is in progress for nursing and physiotherapy data. In Norway, for example, the ELIN-K PROJECT – Electronic interchange of health information in community care – was instigated by the Norwegian Nurses Organisation. The aims of this project are to: develop national standards for electronic information exchange (electronic messages) between community care services, hospitals and GPs; and to test and pilot the solutions in all major electronic patient record systems in Norway. Through this project, the vision is to ensure access to the correct health information, by the right person and at the right time. Furthermore, the Norwegian Nurses Organisation (NNO) has recommended the integration of the International Classification for Nursing Practice (ICNP) and is promoting its integration into Electronic Health Record systems across Norway. ICNP, a product of the International Council of Nurses (ICN), is an agreed terminology or dictionary of terms that encourages nurses to describe and report their practice in a systematic way. The resulting information is used reliably to support care and effective decision-making, and to inform nursing education and health policy. Both nurses and the people they care for have a right to expect good information about health and illness, and about services and treatments. However, the quality of this information currently varies. Although this concern is not confined to Norway, the NNO has recognized a need, at a national-level, to focus attention on the language used to describe nursing and to work towards a unified approach. In June 2018 a taskforce investigation led by high-level national authorities recommended ICNP in nursing practice in Norway. This will provide nursing data that will improve patient safety, quality in healthcare, gaining an increasement in nursing visibility.

Financing

The growing demand for home-based long-term care has resulted in high-income countries in an expansion of benefit packages covered by public financing schemes, with the public expenditure on LTC mostly linked to the dependency status of the population, the model of LTC provision (organisation and financing of the system, which shape the mix between formal, paid care and informal care) and availability of human resources.

Whether a country relies mainly on formal care or informal care and whether formal care is largely provided in institutions or at home are important determinants of public expenditure on LTC. All EU Member States are involved in either the public provision and/or financing of formal LTC services, although the degree to which this is the case varies across EU Member States.A peculiar case is the Danish one, where annually the Government makes a financial agreement with the municipalities (responsible of the primary care) as well as the regions (responsible of the hospitals). In the agreement for 2019 increased funds are earmarked for the health system in general. However, the increase does not even correspond to the expected expenses due to the demographic changes. Nonetheless, a positive development is that some funds are reserved for a lift of competencies for the health professionals in the municipalities.

In Norway the municipalities are responsible for providing long-term care and contract also to some extent with private providers. Cost-sharing for institutionalized care is income-based and set at 75 percent to 85 percent of patients' income. The levels of care at home or in a nursing home are determined by the municipality. Only about 3 percent of nursing homes are private, and for home nursing care the proportion is even lower. Patients may purchase home nursing care and other services from private providers as a supplement to services by public home care. In some densely populated areas, patients themselves have a choice of home care provider or nursing home. People under 67 with permanently reduced functioning who live at home have a right to a personal assistant who will aid them according to their preferences. Very few patients pay individually for full-time private nursing home care. End-of-life care for terminal patients is often provided in specific wards within dedicated nursing homes. There is a system in place for informal caregivers to apply for financial support from the municipalities. The GPs are financed 100 percent by the central government, while the remaining services must be financed by the municipalities and the patients.

The municipalities do not prioritize task allocation, interdisciplinary cooperation or integrated services, because there are no incentives to build competence that compete with the GPs, because they are "free" for the municipalities. Still, it is difficult to get the GPs involved in long term care patients. The coordination reform in Norway has to a small extent led to increased capacity in the healthcare sector in the municipalities. Increased competency and knowledge in the healthcare sector has been limited. At the same time, patients have more complex illnesses and diseases, requiring broader knowledge and skills.

In parallel, Croatia has adopted the Social Welfare Strategy for the elderly the period 2017-2020. The aim of the Strategy for the elderly in the social welfare system was to provide a higher level of social welfare quality for the elderly, to create a basis for funding NGO projects and to provide service providers with access to EU funds to provide services for the elderly in the community not covered by the social care, and to older people, by increasing the quality of life and allowing them to stay longer in their own home. In Germany, LTC is financed by a public insurance into which every employee and every employer pay equal parts based on the employee's salary. Currently 2.55 % (2.8% for people without children) of the gross salary. In 2017 36 billion EURO contributions were received. In 2017 we had 3.3 million beneficiaries. Benefits range from 316 EURO per month (low degree of dependency and care in the family) to 2005 EURO (resident in nursing home with high degree).The extent of benefits depends on the level of impairment of self-reliance (5 degrees) and kind of service (at home by family member, at home by nursing agency or at nursing home). The central paradigm is that the insurance covers only part of the cost. In Germany, most people needing long term care are being cared for at home. In case of care in a nursing home the resident has to cover part of the cost. If pension or private assets are not enough, the social welfare (communities) has to cover the difference. Regarding the medical treatment of chronic conditions, this is being covered by the health insurance (this is only partly applicable in nursing homes). Although in Italy, long-term care is not specifically financed, being part of the general health system financing plan and the Swedish healthcare system being paid with taxes, it is obvious municipalities play a more central role in financing LTC.

Patient empowerment

Appropriate use of patient data has great potential not only to improve quality of care but also to empower patients and enable greater involvement in care decision-making. In the Czech Republic for example, the Transplant Ambassador makes use of patients' own data to improve their knowledge about their condition and the recommended treatment options for irreversible kidney failure. This allows the patients to be more autonomous when making decisions about their future treatment, including about kidney transplant from a living or deceased donor. Over one hundred nurses working with the target group in nephrology practices and haemodialysis centres received specialist training in this area and were involved in this project. These nurses discuss the treatment options with the patients in detail, which empowers the patients to be actively involved in their treatment.

In Cyprus, for example, the EFN Member CYNMAs initiative led to the introduction of regulations of the Nursing and Midwifery legislation since 2012: Code of Nursing Ethics; Code of Midwifery Ethics; Code of conduct of Midwives; Code of Standards for Professional Nursing Practice; Framework of Nursing responsibilities; Framework of Nursing responsibilities. With these provisions it became clear that it is the responsibility of nurses & midwives to foster patient's independence, to empower and to teach and counsel patients, by recognizing and respecting their involvement in the delivery of care (e.g.: Community Nurses delivering Home Nursing - involve patients and their care-givers in all procedures- to get over the barriers of their disabilities and enhance their independency; Diabetic Nurses working in Diabetic Clinics - educate and empower people on self-care).

Another concrete example is in Finland, with the Chronic Care Model. The Ministry of Social Affairs and Health has in 2008 given out the Functioning health centre action plan and based on that has been produced the Chronic Care Model, a guide to higher-quality chronic illness management within primary care. It is based on the work done by Wagner 1998. The target group/ones benefiting of this model are principally clients with several chronic diseases and/or persons needing/using a lot of health services. Case management basically is: screening and active inviting clients (by client record) – making an appointment with medical doctor or/and nurse case manager; assessing care needs, resources and risks; arranging medical examination (lab, x-ray. etc.); drawing up care plan together with client, medical doctor and other professionals taking part in client's care; monitoring client's condition and carrying out care according to care plan; with the core idea to support and monitor client's self-care: Informing/Guiding/Supporting self-care skills/Empowering, motivating, verifying/ Coordination and consultation. The concept has been adapted for the primary health care services in the city of Hämeenlinna since 2010. Patients with multi chronic diagnoses are referred and actually invited to primary health care. Each client has an own case manager (a nurse with advanced competence/role). S/he will coordinate the client's care based on the health and care plan and client's needs. The client decides what are the issues on which he/she wants to have changes to occur.

In Iceland, together with a growing number of CNSs and APNs, there has been the development of nurse-led clinics where there is a special emphasis on assisting patients and their families towards greater self-management, particularly in relation to the treatment of long-term illnesses. Nurse-led clinics are operated either in collaboration with hospitals or primary health care centres as outpatient clinics for a range of patient groups and their families. Nursing therapy based on the ideology or models of self-management is practised in these outpatient clinics. Examples include clinics for patients with chronic pulmonary-, cardiac- and renal diseases, diabetics (both children and adults), the parents of infants with sleep problems, parents experiencing dysphoria during pregnancy (such as anxiety, depression and addiction), adolescents, and patients with urinary incontinence and chronic ulcers. Also, in Ireland, a specific example of patient empowerment is Community Orientated Diabetes Education (CODE), a structured diabetes education programme, which was set up in response to the need to provide equitable access to diabetes community services across the country. This is just one of several structured diabetes education programmes available for patients in Ireland. CODE is delivered to people with Type 2 diabetes attending primary care centres by the Diabetes Federation of Ireland's healthcare professional staff or practice nurses with a recognised diabetes qualification who have been trained as CODE Educators. CODE is fully supported by the Federation and the HSE. Feedback from participants has been very positive and those who completed the course are more interested in taking ownership of the condition and are doing all they can to optimise control of their diabetes.

In Poland, the Polish Nurses Association (PNA, Szczecin District Board) via the Library Development Program partnered with 20 libraries, where to teach education and information about the prevention of lifestyle diseases, cancer, and what actions to take in injuries and accidents. The project "Health Education in the library - health nursing community" assumed the implementation of at least one meeting in every library. The aim of the project was to: promote informal health education - executed in close collaboration in environment between nurses and librarians in public libraries operating in rural areas and small towns in Poland. The role of leaders in this project leaders take the local centres in which they were cooperated: librarian and nurse - a professional educator in the field of health. The advantage of this approach was the use of the existing potential of the library as a neutral point of access to information and knowledge, including meeting and activity of many types, including health education. Involvement in the project allowed the use of the nursing environment far too often unused resources of professional knowledge and experience in the field of prevention and health promotion of the profession, and thus helped to raise awareness of the health of the local community gathered around the libraries participating in the project.

Conclusion

The analysis of the EFN Members' responses to the twenty policy reports developed out of respective Tour de Table exercises, reveal significant areas for policy attention that hold benefit for countries across Europe. Nurses' real-world experiences from the frontline of healthcare are a vital resource to inform and support EU health policy making.

It is clear that nurses contribute in significant ways to EU healthcare, and work actively towards containing and overcoming the major issues that challenge healthcare in the EU. Nurses support the Prevention agenda through leading on vaccination, fighting infectious diseases, antibiotic stewardship, infection control, health promotion and improving access to healthcare. Through Primary care, nurses work with EU citizens through leading on new developments and expand their practice to meet the needs of patients, families and communities through such roles as family nursing, advanced nurse practitioners and nurse prescribers.

Nurses are also a key link enabling Integrated care, working passionately to improve quality, ensure patient-centred services and harness the potential of eHealth. As the single largest health professional group, nurses' experience is central to the Workforce agenda in Europe and within this report raise concerns relating to the accuracy of data, impact of the financial crisis, continued professional development and the benefits of mutual recognition. Finally, nurses are largely the ones ascribed with the collection of accurate, useful and Patient-centred data, and their real-world experience provides insights into the opportunities and complexities of data sharing, as well as the potential of using patients' own data for patient empowerment and involvement in their care decisions.

Drawing on the current synthesised report, based on the EFN Members' input through the Tour de Table policy support tool, the EFN recommends to the European institutions, Governments and relevant health stakeholders to:

1. Invest in capacity building to empower nurses as the frontline healthcare professionals delivering the majority of healthcare to citizens across Europe;

2. Promote the development of advanced nurse practice with extended prescribing rights to ensure safe and efficient access to medications for patients;

3. Support the exchange of best practice on the five themes identified in the present report, to facilitate mutual learning among countries;

4. Provide support for primary care nurses to enable delivery of preventative and curative care closer to where citizens work and live their lives;

5. Develop evidence-based decision-making capacity in nurses to support them fulfil their extended health remit for the benefit of patients, families, and communities across Europe.

The EFN Members call for coordinated action among all relevant EU health stakeholders to ensure nurses and nursing meet society's mandate to protect and promote the health of Europe's citizens, through the provision of safe and high-quality nursing care across settings, regions and countries.

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The European Federation of Nurses Associations (EFN) was established in 1971 and is the independent voice of the profession. The EFN consists of National Nurses Associations from 35 Countries in Europe, working for the benefit of 6 million nurses throughout the European Union and Europe. The mission of EFN is to strengthen the status and practice of the profession of nursing for the benefit of the health of the citizens and the interests of nurses in the EU & Europe.

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