front line care

Report by the Prime Minister's Commission on the Future of Nursing and Midwifery in England

2010

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Dear Prime Minister

It has been my privilege to chair your Commission, which was established in March 2009 to explore how the nursing and midwifery professions could take a central role in the design and delivery of 21st century services. It built on Lord Darzi's 2008 report of the NHS Next Stage Review, High Quality Care for All, and considered all branches of nursing as well as midwifery, in all settings, services and sectors within and outside the NHS.

This is the first overarching review of nursing and midwifery in England since the Committee on Nursing chaired by Asa Briggs, now Lord Briggs of Lewes, reported in 1972. The landmark Briggs report was a reference point throughout my nursing training; I would never have imagined then that I would have the privilege of chairing the next major review in 2010.

The Commission's terms of reference were as follows:

- Identify the competencies, skills and support that frontline nurses and midwives need to take a central role in the design and delivery of 21st century services for those that are sick and to promote health and wellbeing. In particular, identify any barriers that impede the pivotal role that ward sisters/charge nurses/ community team leaders provide.

- Identify the potential and benefits for nurses and midwives, particularly in primary and community care, of leading and managing their own services.

- Engage with the professions, patients and the public in an interactive and robust dialogue which will identify challenges and opportunities for nurses and midwives.

In response, the Commission looked at nursing and midwifery today in the context of current socioeconomic, health and demographic trends, and dispelled some myths and misunderstandings. It also developed a value-based vision of the future that sees nurses and midwives in the mainstream of service planning, development and delivery, backed up by the necessary education, continuing professional development and supervision, and by supportive management and workplace cultures.

This report endorses important existing directions of travel, and where necessary proposes to accelerate the pace of change. It adds new thinking about how best nursing and midwifery can support service users, families and local communities. Throughout the Commission's work programme, it has also been mindful of widely publicized variations in the standards of nursing and midwifery care. Commissioners deplore these unacceptable failures, and propose measures to level up and ensure high quality care for all.

Most service users continue to be highly appreciative of the work of nursing and midwifery staff, but this is no cause for complacency. Condemning poor practice is not sufficient: we all need to understand why it occurs and how to prevent it. To restore public confidence, the Commission proposes that nurses and midwives restate their commitment to the public and service users in a pledge to deliver high quality, compassionate care. By upholding the pledge, nurses and midwives everywhere can turn their anger and disappointment at poor practice into positive action.

Truly compassionate care is skilled, competent, value-based care that respects individual dignity. Its delivery requires the highest levels of skill and professionalism. Tackling poor practice, however, is not solely the responsibility of individual nurses and midwives. Significant improvements are needed in many of the organizations and teams in which they work.

Health service boards and managers must play their full part in taking corporate responsibility for care and ensuring that nursing and midwifery voices are heard and heeded at every level. All must work together to identify and end the individual and system failures that underlie poor quality care. They must create cultures that welcome and embed innovation and excellence, and value and care for the carers.

Nursing and midwifery today

We are all likely to know a nurse or midwife in our own family, street, town or workplace, as trusted members of the community. Nursing and midwifery staff are a huge resource: they are the largest group of staff in Europe's biggest employer, the NHS. There are well over half a million registered nurses and midwives in England, 90% of them women, plus an unknown and growing number of nursing and maternity support staff. With over 20 600 places commissioned in 2009, nursing and midwifery students are probably the largest student body in England.

Nursing and midwifery account for a large share of public spending, including over £13bn spent in 2009 on NHS pay and pre-registration education alone. Despite the size of this spend, relatively little is known about the cost-effectiveness of their work, there is too little evaluation and existing research is often ignored. We simply do not know whether the public gets the best return on this investment, and whether the potential of nursing and midwifery capital is fully exploited.

A 'carequake' is fast approaching: the massive and growing requirement to provide skilled care for people with many different needs – arising from long-term conditions, drug and alcohol addiction, the complex needs of ageing, problems in the early years, and much more. Nurses are centre stage to meet these needs and must be properly equipped and supported to do so.

The public image of nursing is out of date in many ways. A new story of nursing is needed to recruit suitable talent and demonstrate that nurses are not poorly educated handmaidens to doctors. One traditional figure, however, should be restored to her former position – the ward sister. I strongly believe that immediate steps must be taken to strengthen this role and enhance its clinical leadership and visible authority, as the guardian of patient safety and the role model for the next generation of nursing students.

Nursing and midwifery have fine traditions of creating education and career opportunities for people whose background and education gave them few such chances. Nursing and midwifery degrees are an important route to social mobility: nurses and midwives are often the first person in the family to get a degree, often working class women, often from black and minority ethnic groups.

The prior decision to move to degree-level registration of all nurses in England (as is already the case with midwifery) was a major talking point during our work programme. The debate exposed many myths and misunderstandings, perhaps above all the mistaken idea that compassion can be separated from competence. Compassion is vital, but it is not enough: nurses and midwives must also be well educated to deliver safe, effective care.

The Commission believes that degree-level registration is the right way forward to secure high quality care, strong leadership, and parity with the rest of the UK, other professions and other countries. Teachers and researchers are an essential part of the picture, but this is not about creating a workforce of academics. The entry gate must remain wide to attract everyone with the right values and potential.

My own experience illustrates the social mobility that nursing has enabled through investing in people, skills and education. After I left my secondary modern school I worked as a clerk in the NHS, and was encouraged to become a nurse by a senior sister. I sat an entry examination and was accepted to train as a state registered nurse. That was my first step to gaining the knowledge and confidence that I have developed and will stay with me for life.

Our recommendations

The Commission has made 20 high-level recommendations on seven key themes that address these issues: high quality, compassionate care; the political economy of nursing and midwifery; health and wellbeing; caring for people with long-term conditions; promoting innovation in nursing and midwifery; nurses and midwives leading services; and careers in nursing and midwifery. They are summarized below, and given in full in Part 5, Chapter 2.

High quality, compassionate care

A pledge to deliver high quality care
Nurses and midwives must renew their pledge to society and service users to tackle unacceptable variations in standards and deliver high quality, compassionate care.

Senior nurses' and midwives' responsibility for care
All senior nursing and midwifery managers and leaders must uphold the pledge, accept full individual managerial and professional accountability for high quality care, and champion quality from the point of care to the board.

Corporate responsibility for care
The boards of NHS trusts and other health employers must accept full accountability for commissioning and delivering high quality, compassionate care, and must recognize and support directors of nursing to champion care at board level.

Protecting the title 'nurse'
To ensure public protection and allay confusion about roles, titles and responsibilities, urgent steps must be taken to protect the title 'nurse' and limit its use to nurses registered by the Nursing and Midwifery Council.

Regulating advanced nursing and midwifery practice
Advanced nursing practice must be regulated to ensure that advanced practitioners are competent to carry out their roles and functions. The regulation of advanced midwifery practice should also be considered.

Regulating support workers
To ensure they deliver care that is effective, safe, patient-centred and compassionate, some form of regulation must be introduced for the support staff to whom registered nurses and midwives delegate tasks.

The political economy of nursing and midwifery

Evaluating nursing and midwifery

To ensure the public gets the best return on its large investment in nursing and midwifery, more studies of their clinical, social and economic effectiveness should be commissioned, and the findings of all such evidence should be fully utilized.

Measuring progress and outcomes

The development of a user-friendly national framework of indicators of nursing outcomes must be accelerated, and further work should be done to identify better outcome indicators for midwifery.

Health and wellbeing

Nurses' and midwives' contribution to health and wellbeing

Nurses and midwives must recognize and scale up their important role in the design, monitoring and delivery of services to improve health and wellbeing and reduce health inequalities.

A named midwife for every woman

The midwifery contribution to improving health and wellbeing and reducing health inequalities must be enhanced by ensuring every woman has a named midwife to provide support and guidance and ensure coordinated care.

Staff health and wellbeing

Nurses and midwives must acknowledge that they are seen as role models for healthy living, and take personal responsibility for their own health. Their employers must value and support staff health and wellbeing.

Caring for people with long-term conditions

Nursing people with long-term conditions

The redesign and transformation of health and social care services must recognize nurses' leading role in caring for people with long-term conditions, and all barriers that prevent them from utilizing their full range of capacities and competencies must be removed.

Flexible roles and career structures

Nurses must become competent to work across the full range of health and social care settings, and career structures must enable them to move easily between settings and posts.

Promoting innovation in nursing and midwifery

Building capacity for innovation

Nursing and midwifery fellows should be appointed as champions of change and leaders of transformational peer review teams that raise standards and embed innovation and excellence.

Making best use of technology

Nurses' and midwives' capacity to understand, influence and use new technologies and informatics, including remote care, should be improved.

Nurses and midwives leading services

Strengthening the role of the ward sister

To drive quality and safety and provide visible, authoritative leadership and reassurance for service users and staff, immediate steps must be taken to strengthen the linchpin role of the ward sister, charge nurse and equivalent team leader in midwifery and community settings.

Fast-track leadership development

More opportunities must be available to develop nursing and midwifery leaders, and to fast-track successful candidates to roles with significant impact on care delivery.

Careers in nursing and midwifery

Educating to care

To ensure high quality, compassionate care, the move to degree-level registration for all newly qualified nurses must be implemented in full. All nursing and midwifery staff must be fully supported if they wish to obtain a relevant degree. There must be greater investment in continuing professional development.

Marketing nursing and midwifery

Campaigns must be launched to tell new stories of nursing and midwifery that will inspire the current workforce, attract high calibre candidates, highlight career opportunities, educate the public, and update the public images of the professions.

Integrating practice, education and research

Urgent steps must be taken to strengthen the integration of nursing and midwifery practice, education and research; develop and sustain the educational workforce; facilitate sustainable clinical academic career pathways; and further develop nurses' and midwives' research skills.

The way forward

This agenda is ambitious, as it should be. Acting on it would help provide an excellent return on the investment required. Achieving it will require sustained effort not only from the Government, but also from employers, educators, other stakeholders, and not least nurses and midwives themselves.

Speaking as a nurse, I am passionate about the value that nurses and midwives add to health care, health and wellbeing – working with the community to challenge health inequalities and improve people's life chances. Our concern for humanity is international; it was a nurse, Dame Claire Bertschinger, who encouraged Sir Bob Geldof to launch Live Aid.

Nurses and midwives do invaluable development and relief work in many parts of our troubled world, working for health as a bridge to peace. They include nurses from our Defence Medical Services, caring for those involved in conflict in Afghanistan and elsewhere with bravery and compassion, at the same time using advanced technology that enables rapid treatment of severe injuries.

Midwives have joined worldwide alliances to make childbirth safer for the women and babies who will die in many thousands without access to skilled maternity care. They not only use their skills but also raise their voices to demand that world leaders act to prevent unnecessary maternal and neonatal deaths.

So much has changed for the better since my days in clinical practice – advances in technology, care and treatment as well as greater prosperity leading to people living longer and surviving serious illness. From the skill and compassion to look after frail elderly people, to high-tech care of premature babies, we are able to practise our science and art of care with a developing evidence base. Yet the move to full professionalization of nursing and midwifery is long overdue, to recognize nurses and midwives as equal members and sometimes leaders of multidisciplinary teams, and as independent professionals in our own right.

Thousands of participants – the public, health service users, nurses and midwives, other health workers and many other stakeholders – took part in our engagement exercise. I thank them warmly for their role in shaping this report, which reflects their major concerns and ideas. The quality of this report owes much to the vision, passion and expertise of the Commissioners. The Support Office, with commitment and tenacity, delivered an efficient process that kept us all on schedule. I would especially like to thank Jane Salvage for her expertise in editing the Commission report. I would also like to thank the Department of Health, especially the Chief Nursing Officer, Dame Christine Beasley and her team, for hosting and supporting the work.

Prime Minister, I am delighted to commend to you this historic report from your Commission on the Future of Nursing and Midwifery in England. We look forward to the Government response. This report, and subsequent action on the recommendations, should help to reinforce the position of nurses and midwives as valued professionals at the centre of developing, leading and shaping as well as delivering high quality, compassionate care, now and for future generations.

Ann Keen MP
Chair of the Commission

Commendation from Commissioners

As members of the Prime Minister's Commission on the Future of Nursing and Midwifery in England, we commend this report to the Prime Minister. Each one of us has a background in nursing or midwifery, so we are fully aware of the wonderful work that nursing and midwifery staff do every day – as well as the challenges and barriers that can prevent delivery of high quality, compassionate care for all.

The changing priorities for health and health care have profound implications for the way nurses and midwives practise, the shape of teams and services, and many aspects of management, education and development. These issues are already receiving attention from policy-makers, health service employers, educational institutions and, of course, front-line nurses and midwives and their organizations. Even more needs to be done, as a matter of urgency. The renewed focus on high quality care puts nurses and midwives in pole position to improve health outcomes, the quality of care and the experiences of service users – and their expertise will be increasingly in demand as the need for skilled care grows apace.

We hope that this report will contribute to taking these issues forward, and we urge you to join us in turning our vision into reality. This will require nothing less than the renewal and revitalization of nursing, and full recognition of the autonomy of midwifery. It will demand honesty about where things are going wrong, and commitment to making the systemic, social and cultural changes needed to put them right. We urge you to support us and all nursing and midwifery staff in our quest to deliver world-class health care to the people of England in the 21st century.

Gail Adams
Head of Nursing, UNISON

Dame Christine Beasley
Chief Nursing Officer for England, Department of Health

Sue Bernhauser
Dean of the School of Human and Health Sciences, University of Huddersfield; chair of the Council of Deans of Health UK

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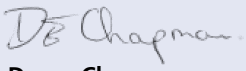

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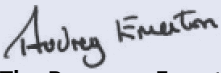
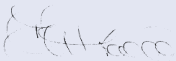


The Baroness Emerton
Crossbench life peer, House of Lords



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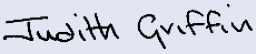

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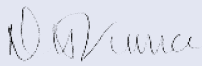

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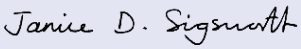

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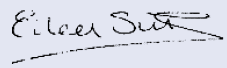

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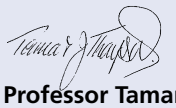

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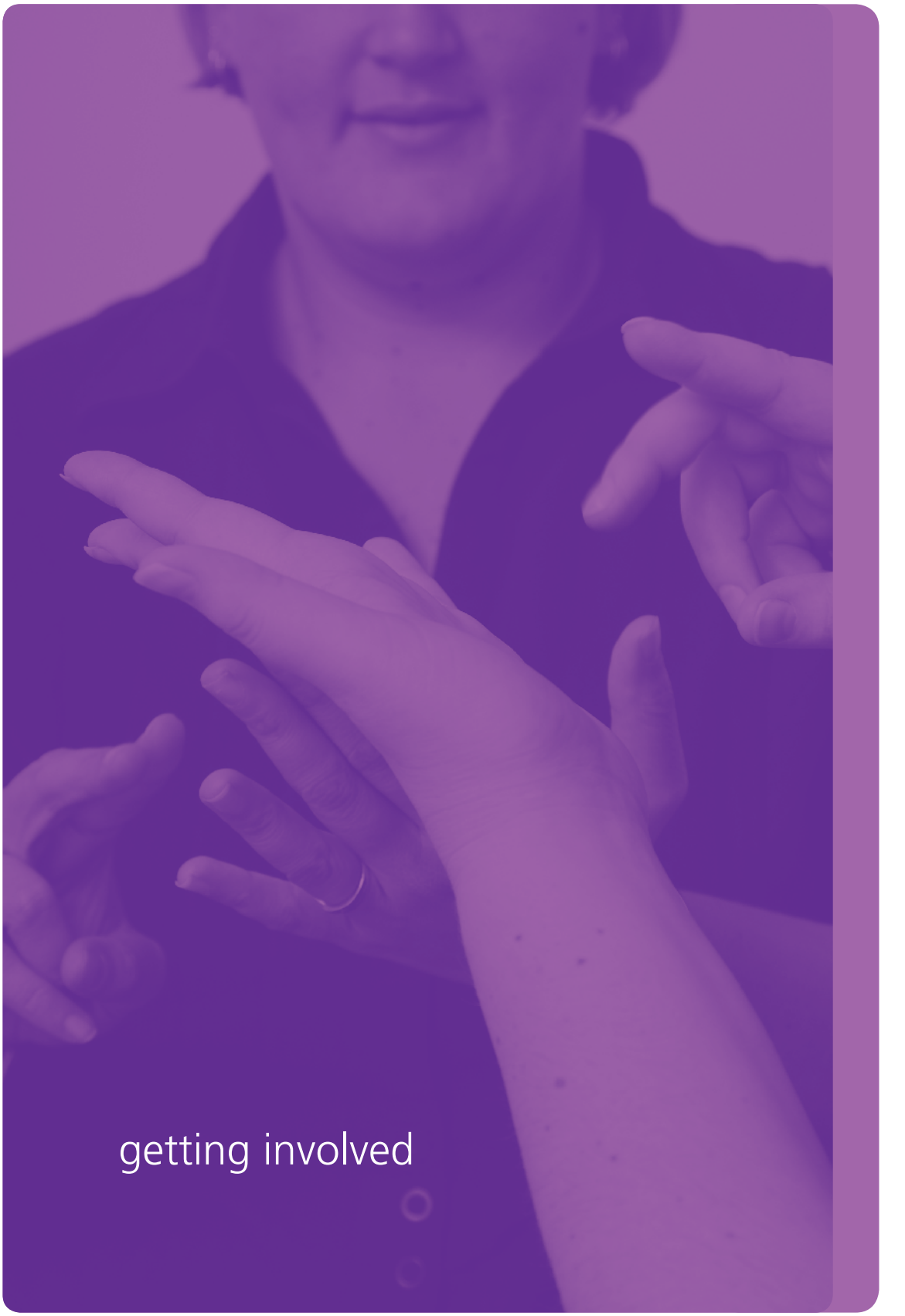
Part 1

Introduction

Chapter 1.1 **Why the Commission was established**
Chapter 1.2 **The Commission's programme of work**



getting involved

Chapter 1.1
Why the Commission was established

Nurses and midwives are responsible for so much of what we have achieved over the last 10 years. They are experts who know best how the service can meet the needs of patients and their local communities. We must be bold in putting them in control and at the heart of our plans for a world-class NHS.

The Rt Hon Gordon Brown MP, the Prime Minister, launching the Commission on 10 March 2009

England's nurses and midwives are the lifeblood of the NHS and other health services, and have always been at the heart of good health care. In 2009 there were well over half a million nurses and midwives on the Nursing and Midwifery Council (NMC) register residing in England. As the largest group of registered professionals in the NHS, they are a huge workforce with great power and potential to influence health and health care. They are ideally placed to improve the experiences of service users and families, and they influence health in a wide range of health, social care and community settings. In the last decade nurses have acquired greater responsibility as autonomous and interdependent practitioners: they lead programmes of care, act as partners and employers in general practice, and also lead their own services and run their own clinics. Many are specialists who can prescribe medicines and treatments, and make referrals to other health and social care professionals. Midwives are autonomous practitioners able to lead their own services, make referrals, and supply and administer certain medicines.

Box 1.1: A note on terminology

This report generally uses the term 'service user' to describe any health and social care service user who requires the professional services of a nurse or midwife for health promotion, illness prevention, assistance in pregnancy and childbirth, care or treatment. 'Service users' comprise hospital in- and out-patients, clients, residents, and all similar categories in current usage.

The terms 'nurses' and 'midwives' refer exclusively in this report to people registered as nurses (RN) and/or midwives (RM) with the Nursing and Midwifery Council. 'Nursing and midwifery' is a collective term for the two professions, comprising solely those registered as RNs and RMs.

Nurses and midwives work not only in the NHS but for many other health-related organizations. We use the term 'health system' to mean the sum total of all the organizations, institutions and resources in England whose primary purpose is to improve health, including healthy pregnancy and childbirth, and provide end-of-life care.

Midwifery won statutory recognition as a profession in England in 1902, and nursing in 1919. Since then nursing and midwifery roles, responsibilities and structures have evolved and improved in many ways, keeping pace with people's changing needs and expectations as well as their continuing wish to feel safe, respected, involved and cared for with compassion and competence. Changing times and priorities continue to require changes in nursing and midwifery. Furthermore, the public foots a large bill for nursing and midwifery services. At a time of economic constraint, it is even more important to ensure that this money is wisely spent, and the costs and benefits fully researched and analysed.

Current health policy aims to deliver world-class services. Its main directions of travel have enormous implications for nursing and midwifery, and indeed largely depend on them for successful implementation. These changes demand a new style of professionalism that responds more directly to service users' needs; delivers consistent quality in daily practice; requires more autonomy from central government wherever front-line professionals show the ambition and capacity to excel; and invests more in practitioners' skills (Cabinet Office 2008).

Evolving health and care priorities in tough times have profound implications for the way nurses and midwives practise, the shape of their teams and services, and many aspects of their education and development. These issues are receiving attention from policy-makers, health service employers, educational institutions, and of course front-line nurses and midwives. The renewed focus on high quality care puts nurses and midwives in pole position to improve health outcomes, the quality of care and the experiences of service users. These issues are being addressed locally, regionally and nationally, including an extensive programme led by England's Chief Nursing Officer.

Even more needs to be done, however, to empower nurses and midwives to deliver world-class services. Nurses deliver compassionate and effective care every day, yet unacceptable variations persist in the standards of care, often associated with systems failures and real or perceived constraints on effective practice. The public regard nurses with affection and respect, but they are also rightly concerned about these well-publicized shortcomings, which sometimes have tragic consequences. They expect and deserve high quality care and they do not always get it.

Midwives continue to deliver safe services that contribute to England's comparatively low maternal and neonatal mortality rates. Nevertheless, there are still areas for improvement in maternity care (Healthcare Commission 2006). These may be linked with unnecessary medical interventions; limited choices and involvement in decision-making for women staff shortages; and organizational structures that are not conducive to best practice.

For all these reasons the Prime Minister felt it was timely to establish a commission on the future of nursing and midwifery in England, to advise on how the professions could implement and accelerate the ambitious long-term change agenda set out in *High Quality Care for All* (Department of Health 2008). At its launch, he gave the Commission the following terms of reference:

- Identify the competencies, skills and support that frontline nurses and midwives need to take a central role in the design and delivery of 21st century services for those that are sick and to promote health and wellbeing. In particular, identify any barriers that impede the pivotal role that ward sisters/charge nurses/ community team leaders provide.
- Identify the potential and benefits for nurses and midwives, particularly in primary and community care, of leading and managing their own services.
- Engage with the professions, patients and the public in an interactive and robust dialogue which will identify challenges and opportunities for nurses and midwives.

Our remit covered England, and considered all branches of nursing as well as midwifery, in all settings, services and sectors within and outside the NHS. On many issues we were able to discuss nursing and midwifery together as they share much common ground, but there are also important differences and, where necessary, nursing and midwifery are the subject of separate discussion and recommendations in this report. Although our terms of reference refer specifically to registered nurses and midwives, they cannot be considered in isolation from the wider nursing and midwifery families, which include people in various support roles including health care assistants, assistant practitioners and maternity support workers.

Going further, faster

We have been conscious of the Commission's historic role in conducting the first overarching review of nursing and midwifery in England since the Briggs report (Committee on Nursing 1972). The evolution of the nursing profession in the intervening decades has been a largely untold success story of the transformation of a traditionally subordinate, low-paid occupation into a competent, well-educated profession that respects human rights and values compassion, and whose practice is increasingly evidence-based. Midwifery has always been independent, though not always recognized as such; it has continued to improve its practice, strengthen its evidence base and assert its autonomous role.

We noted how much has changed since 1972 – but also much that has not changed that should have. How might the Commission help to accelerate progress? By taking a long-term overview we can highlight important existing and potential directions of travel, particularly the need to tackle longstanding problems and build on changes already shown to benefit service users and boost performance and satisfaction. Persistent underlying barriers are hindering nursing and midwifery from moving far enough, fast enough. They include a society that wants compassionate care but does not fully understand the expertise needed to give it; the health system's adherence to a primarily biomedical model of health and disease; and a culture in nursing and to a lesser extent in midwifery that is sometimes subservient and reluctant to challenge itself or others. Unless these barriers are overcome, the pace of change will not accelerate sufficiently to meet current and future challenges.

Our engagement process demonstrated to us that the work of nurses, and sometimes of midwives, remains largely invisible, often poorly understood and at times undervalued. Even some nurses and midwives had only a limited sense of their potential to meet future health needs and demands in important new ways. By putting service users at the centre of care, and urging England's nursing and midwifery workforce to see itself as part of the solution, we hope to contribute not only to further reforms within the professions, but to overall improvements in health and social care.

Chapter 1.2
The Commission's programme of work

This chapter describes how the Commission was set up and conducted its work. It deals purely with the process; the outcomes of our engagement and deliberations follow later.

The Commission was launched by the Prime Minister on 10 March 2009, and was asked to report by the end of March 2010. The Commission was independent, with its secretariat funded and hosted by the Department of Health, England. The Chair was Ann Keen MP, Parliamentary Under Secretary of State for Health Services in the Department of Health, the first nurse to hold ministerial office in England. The Commissioners were 20 expert nurses and midwives working in practice, management, education, research, development, advocacy, policy-making and legislation, in a range of organizations including the House of Lords; the Department of Health; NHS acute hospital and primary care trusts; social enterprises; university nursing and midwifery faculties; professional organizations and trade unions; and nongovernmental organizations. We were assisted by a support team of civil servants and health experts, and by other national and international advisers. Part 5, Chapter 4 gives full details.

Our third term of reference asked us to 'engage with the professions, patients and the public in an interactive and robust dialogue which will identify challenges and opportunities for nurses and midwives.' We welcomed this as an invaluable opportunity to hear the views of the public, service users, nurses and midwives and other stakeholders on what they valued about nursing and midwifery, what changes they would like to see, and how these changes could be brought about. The challenges and opportunities identified were instrumental in shaping this report and its recommendations.

Seeking views

During the first phase of our engagement process, which ran from May to August 2009, we sought views from as wide a variety of stakeholders as possible, asking individuals and organizations a series of open questions (see Box 1.2.1). Commissioners took their role as guardians of this process very seriously, and used many different channels and activities to reach different audiences.

The activities were too numerous to be listed individually, but included the following:

- Our Chair wrote to over 300 organizations requesting evidence, opinions and proposals.
- We launched an independent website (http://cnm.independent.gov.uk) giving Commission news; blogs by Commissioners and responses from the public, service users and staff; and interactive facilities to enable organizations and individual people to submit and discuss their views.

Box 1.2.1: The questions we asked

- What are the knowledge, skills and attributes that nurses/midwives require to take a central role in the design and delivery of 21st century services?
- What would you like to see nurses and midwives doing more of and/or doing differently in the future – whether in people's own homes, in the community or in hospital?
- What might be preventing nurses and midwives from doing this now?
- How can these barriers be overcome?
- What is the potential for and benefits of nurses and midwives leading and managing their own services, and what framework and support would be needed for this in the context of the multidisciplinary team?

- We sent communications tools and resources to over 140 organizations, which they used to stimulate debate through their own channels including bulletins, magazines, websites, social networking sites and events.
- Our proactive media strategy informed and stimulated debate through the national, professional and local media, generating coverage in newspapers and professional journals, on television and on websites.
- We promoted the Commission through all Department of Health staff-facing bulletins and a resource pack accessed by over 3000 NHS communicators.
- All 10 NHS strategic health authorities (SHAs) in England publicized the Commission and encouraged engagement via existing networks and forums.
- A listening event was held in Manchester, attended by Commissioners and participants including people with long-term conditions, parents and carers, and members of the public and service users of different ages, genders, ethnicities and social and economic backgrounds. The professionally facilitated day comprised an interactive mix of discussions, informed by a short film, a series of interviews with nurses, midwives and service users, and an online focus group with recent patients.
- Individual Commissioners and Support Office staff promoted the Commission at a large number of public-facing and staff-facing events organized by stakeholders. These included Careers Direct Information, Community and District Nursing Association, Community Practitioners and Health Visitors Association/Unite, Council of Deans of Health, Department of Health National Stakeholder Forum, Department of Health Social Partnership Forum, Learning Disabilities Open Forum, NHS Confederation, NHS Employers, NHS Institute for Innovation and Improvement, Royal College of Midwives (RCM), Royal College of Nursing (RCN), Royal College of Physicians and UNISON. Nearly 800 nurses at the RCN's annual congress completed our questionnaire.

- The Chair, individual Commissioners and Support Office staff held informal meetings with a number of stakeholder organizations, projects and individual experts to outline the Commission's work and discuss the issues.
- The Chair, individual Commissioners and Support Office staff conducted site visits to various organizations employing and educating nurses and midwives across England, where they spoke to service users and staff at all levels and observed innovative approaches to service delivery and education.
- The Council of Deans, RCM, RCN and UNISON jointly hosted a one-day event for students and newly qualified nurses and midwives. Participants came from Birmingham, Coventry, Huddersfield, Leeds, Lincoln, London, Nottingham, Sheffield, Surrey and Worcester, with observers from North Wales.
- The RCN hosted a round table discussion for Commissioners, economists, policy experts, regulators and academics to consider the implications of the economic downturn for nursing and midwifery (RCN 2009a).

Commissioners were particularly keen to elicit the views of seldom-heard individuals and communities. A number of stakeholders ran engagement activities, including events held in partnership with National Voices, an umbrella group for national voluntary organizations representing users of health and social care in England. Many other organizations representing seldom-heard voices responded to the call for views.

International perspectives were developed through exchanges with various organizations and nursing and midwifery experts, including:

- the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine, USA;
- site visits to nursing and midwifery centres of excellence in Washington DC, USA;
- the University of Sydney International Nursing Policy and Research Roundtable, Australia;
- the Joanna Briggs Institute for Evidence-based Healthcare, University of Adelaide, Australia.

We received over 2500 submissions from individuals and organizations representing the views of many thousands of people. These included members of the public; service users; carers; expectant mothers and recent users of maternity services; health workers including nurses, midwives, allied health professionals and doctors; health employers; regulatory bodies; trade unions; professional bodies; local involvement networks; higher education institutions; third sector organizations; individuals and groups representing seldom heard communities; and independent experts. Our website was visited over 14 000 times between May and August 2009.

All this activity and more generated a rich store of evidence and opinion to complement and inform our own discussions and expertise. During the first phase, the Commission met formally four times, and set up working groups. We also had meetings with stakeholders to map and debate the current direction of policy

travel, including the Department of Health, other government departments, the NMC, the Next Stage Review Nursing and Midwifery Advisory Board, and heads of nursing in NHS SHAs. We commissioned working papers on the socioeconomic value of nursing and midwifery, and on the factors that help and hinder community nurses.

Testing phase

After considering the evidence and opinions gathered in the engagement phase, we launched a second phase from October to November 2009 to test our interpretation of the main messages and areas of consensus (Box 1.2.2). We also wanted debate on particular 'hot topics' on which we had found no consensus and few proposed solutions (Box 1.2.3), and sought views on our draft vision statement.

Box 1.2.2: Consensus issues emerging from engagement process

- The need for compassionate care driven by service users.
- The need for nursing and midwifery staff to be technically competent and well educated.
- The need to attract and retain the right number, type and diversity of recruits to nursing and midwifery.
- The need to strengthen leadership at all levels and make it visible.
- The need to tackle poor performance.
- The need to strengthen the commissioning and delivery of pre-registration education.
- The need for nursing and midwifery staff to focus on health promotion, illness prevention, and community-based long-term care.

Box 1.2.3: Hot topics that were tested

- The role of nursing and midwifery in putting service users in the lead of managing their care.
- Improving the health and wellbeing of nurses and midwives.
- Nurses and midwives leading services.
- Transforming workplace cultures and relationships.
- Ensuring the transition to degree-level registration for nursing.
- The need for clarity on the roles and functions of nursing and maternity support workers.
- The need to address the current confusion relating to roles and titles.
- Spreading and embedding innovation.
- Taking responsibility and being held to account for care quality and safety.
- Getting nursing and midwifery staff to engage actively in achieving best value in changing economic, environmental and technological circumstances.

As before, we used a wide variety of communication channels to canvass views. Activities included:

- Joint events with all 10 NHS SHA regions, attended by nursing and midwifery staff, Commissioners, Support Office staff and others. Over 900 nurses, midwives and other participants attended these day-long events, facilitated and co-organized by an independent agency.
- Building on the first-phase listening event in Manchester with public and patients, we held a second event in London for members of the public, service users (including some who had attended the first event), and nursing and midwifery staff from across England.
- East Midlands SHA hosted an event for children and young people, facilitated by young people from Leicester's Children's Council, and an event for NHS professionals working with children and young people.
- A round table discussion was held with the RCM, RCN, the Royal College of Obstetrics and Gynaecology, the Royal College of Paediatrics and Child Health, and the National Childbirth Trust.
- The Prime Minister, Secretary of State for Health, and Commission Chair attended a round table discussion and reception at 10 Downing Street to hear the views of award-winning nurses and midwives.
- Dialogue was encouraged on the Commission's website, which had been visited over 26 500 times by December 2009.

As in the first phase, these events were supplemented by two full Commission meetings; site visits; interviews; the use of stakeholder forums, networks and bulletins; extensive coverage in professional and local media; and presentations by Commissioners at events hosted by a wide variety of stakeholders. After the testing phase, we held three more full meetings and several subgroup meetings to consider the evidence and draft our report, which was published within a year of the Commission launch.

Conclusion

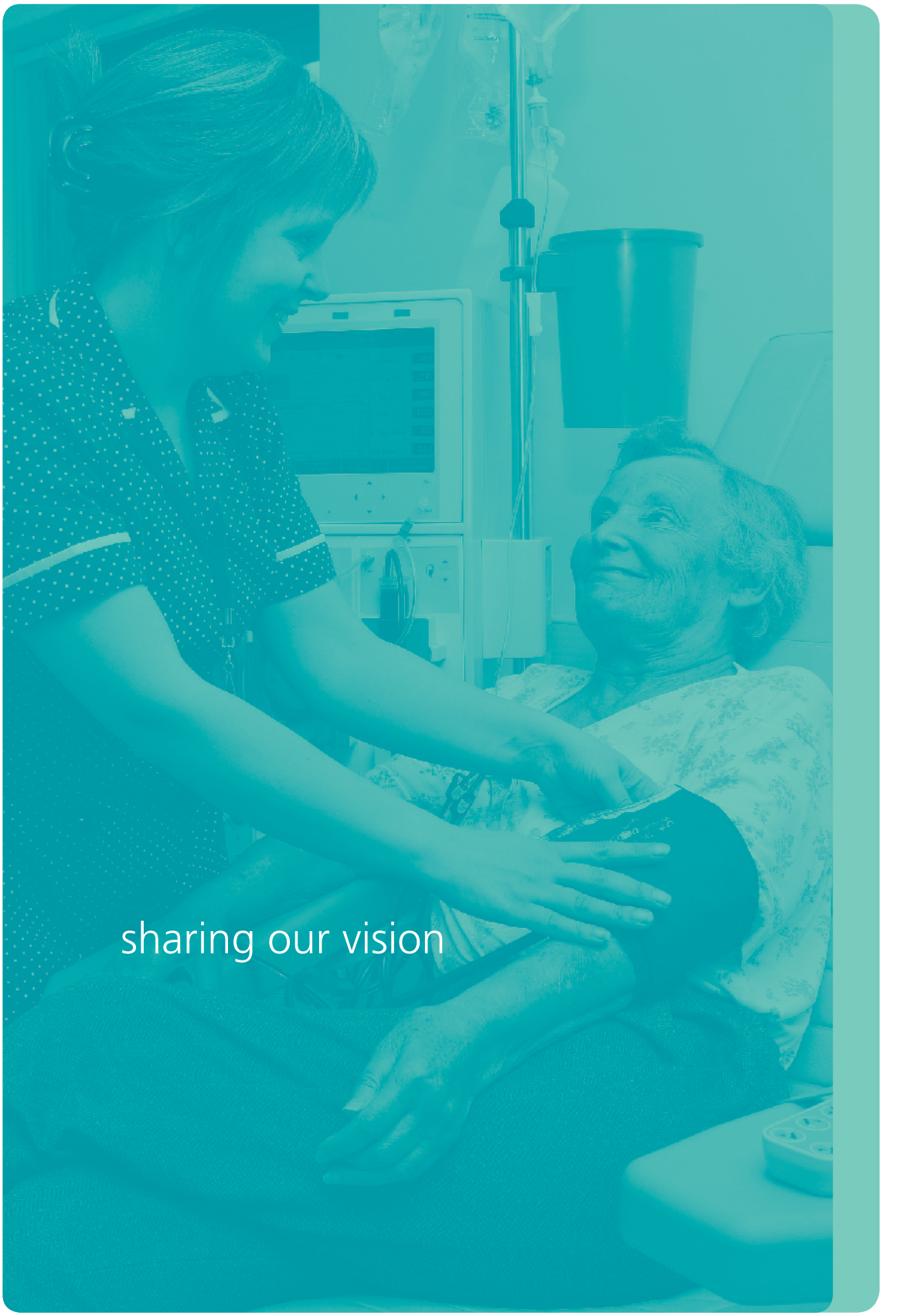
This extensive engagement programme amply fulfilled our third term of reference. As well as providing evidence for our deliberations, we found the discussions and inputs illuminating. To give a flavour of the debate, we will quote extensively from organizational submissions and individual comments we received, and from reports summarizing our key events. All quotations from individual health workers, members of the public and service users are anonymous and given verbatim with normalized spelling and grammar.

We would like to thank everyone who contributed to the debate and supported our work. Their evidence and opinions laid the foundation of our analysis and proposals. While the conclusions are our own, we attempted to respond to widely held concerns on key issues. This fruitful process, underlining the value of involving the public, service users and health workers in policy-making, enabled us to make what we hope will be a useful contribution to shaping the future of nursing and midwifery over the next decade and beyond.

Part 2

Context, policy and vision

Chapter 2.1 **Context and policy**
Chapter 2.2 **Our vision for nursing and midwifery**


sharing our vision

Chapter 2.1
Context and policy

Our work was conducted at a challenging time for society and for health and social care. The challenges we discuss below have major implications for nursing and midwifery, and concerted action is needed to ensure they play their full part in building a sustainable future and upholding the public's entitlement to high quality care. Here we look briefly at the socioeconomic background, health trends and other drivers of demand for health care, and policy responses, as essential context for our case for change and investment in nursing and midwifery.

The socioeconomic context

Three key assumptions underpin our thinking about how health services should change, how that change can be brought about, and what human and financial resources will be available. Our first assumption is that there will be fewer financial resources in the short to medium term, and that this and other factors will impact on staff supply. Our second is that the demand and need for health and health care is changing rapidly. Our third is that action is needed at different levels to create sustainable change in health services.

1 Human and financial resources

We held our Commission at a time of global economic crisis. Ever-rising demand and the spiralling costs of health care, at a time of economic pressures, means health services face tough decisions about spending priorities in the short term, and may not be sustainable in their present form in the longer term. These challenges will also exacerbate some long-term trends and existing problems in maintaining the supply of nursing and midwifery staff, although economic pressures are likely to assist retention and return in the short term. Urgent action is needed to deal with shortfalls arising from the ageing of the workforce, particularly in the community; to promote staff retention and return; and to attract the best recruits to nursing and midwifery, including raising awareness that degree-level registration of nurses and midwives is essential to create a competent, flexible workforce fit for the future.

Managing demand effectively and providing high quality care requires sufficient numbers of highly skilled nurses and midwives available to all patients at all times, as the National Patient Safety Agency told us. Poor care is damaging and even deadly to its recipients, and undermines confidence in services and care-givers. Some employers see cost and quality as trade-offs, but we think the best care is provided at the least cost to the organization. 'It is poor care which brings added financial burdens to the health care organization,' the RCN told us. 'Money is not saved by reducing nursing numbers and diluting skill mix.'

These issues cannot be tackled effectively in isolation, whether in workforce planning or integrating clinical pathways and professional practices. Other health and social care occupations are also looking at their future, and we heard of similar challenges and concerns from concurrent reviews on the future roles

of physicians and of social workers (Royal College of Physicians 2008; Social Work Task Force 2009). A follow-up initiative would be valuable to share all this thinking more formally and identify opportunities to strengthen joint interprofessional planning, working and education across health and social care.

2 Changing health needs, supply and demand

Health care in England faces a challenging future, we heard from the NHS Sustainable Development Unit. 'Beneath the surface, profound changes are also under way that question the model of health care provision familiar to us all for generations. Demographic change, new technologies, a changing climate and seismic shifts in the global economy will affect our lives in ways we find hard to anticipate,' it said (NHS Sustainable Development Unit 2009a). All industrialized countries face similar challenges.

Demands and needs relating to health and health care are changing, while there are major factors affecting the supply of services, as Skills for Health and others told us. The major factors that influence supply and demand include:

- demographic change;
- changing patterns of health and disease;
- rising expectations of the public and service users;
- increased access and choice;
- shift to delivery of more care in community settings;
- continuing social inequality;
- advances in care and treatment; and
- advances in technology for communications and care.

Demographic change in England is leading to a rising birth rate as well as greater numbers of older people (and a greater proportion of them in the population) who are living longer. England broadly follows the general health pattern of industrialized countries: the emergence of new diseases and the re-emergence of some familiar ones; communicable diseases that travel rapidly from country to country; and a 'global epidemic' of noncommunicable diseases such as cancer and heart disease, often triggered by unhealthy environments and risky behaviours (WHO 2006).

The consequence of many of these trends is a huge and growing need for skilled care – the 'carequake'. Dealing with this demand in the coming decade and beyond will require a much stronger focus on preventing and managing long-term mental and physical conditions, including the multiple, complex health needs associated with ageing. So who will provide this skilled care? There are already signs of a 'crisis of caring' fuelled by the low status of care work, whether paid or unpaid. Although most care continues to be provided by England's six million lay carers, families are increasingly likely to outsource caring to other providers. They expect health and social care workers to do what they would formerly have done themselves, and are vigilant for signs of failure.

People in England are healthier and longer-lived than ever before. Yet social changes such as the rise of consumerism and a focus on entitlement have raised expectations to a level that would not be recognized by earlier generations. Service users and carers are much more knowledgeable about their conditions, and many want to be more involved in care planning and decision-making. The emphasis on choice also makes the management of demand more complex. Although surveys show continuing high levels of satisfaction with the NHS, personal experiences of poor care, as highlighted daily in the media, tell another story.

These challenges are not new and were reviewed some years ago in the government-commissioned Wanless reports. The first report said resources were needed not only to satisfy short-term objectives, particularly access to services, but also to invest in balancing supply and demand (Wanless 2002). It said supply could be improved by building the capacity of the workforce; ensuring that health workers were helped to be fit and healthy and worked in safe, health-promoting environments; pay rises; and improving information technology support and renewing premises. The second report focused on reducing demand through illness prevention and tackling the wider determinants of health, and highlighted the cost-effectiveness of action to improve the health of the whole population and reduce health inequalities (Wanless 2004). Unless this major shift came about, it said, 'health services will continue to run faster and faster to stand still.' The financial crisis has made this conclusion even more salient.

3 Achieving sustainable change

The status quo is neither desirable nor feasible; fiscal hardship must be turned into an opportunity for radical reform and service redesign from first principles, along the lines often advocated by nurses and midwives, and proposed to us in many submissions. Action is needed at four different levels to create sustainable change in health services: the individual staff member; the team, unit or department; the institution as a whole, directed by the board and executive team; and the wider health care system (Point of Care 2009).

The way in which change is managed is as important as its content. Historically, health service policy generally failed to take account of nurses' and midwives' concerns and ideas. Nurses and midwives told us they were still often regarded as passive implementers of others' policies, and had to fight many times over for their place at the top table. High quality care for all will not be achieved unless policy-makers, leaders, managers, and nurses and midwives themselves change this mindset and become active, equal partners and change agents.

The policy responses

The last decade has seen many policy-driven changes in health and social care, seeking different ways of addressing longstanding challenges including the need to personalize services in response to changing needs and expectations; drive up quality and improve the management of safety; focus more on disease prevention and health promotion; tackle health inequalities; and achieve best value. A series of reforms made important improvements and resulted in record levels of satisfaction with the NHS, alongside progress by non-NHS health care providers.

The NHS Next Stage Review of 2007-2008 was led by Lord Darzi of Denham, the renowned surgeon who was at that time Parliamentary Under Secretary of State. Nurses and midwives played an active role in this process, which resulted in every NHS SHA developing its own visions and clinical strategies for the future. The review's final report, *High Quality Care for All* (Department of Health 2008), envisages a health service that:

- helps people stay healthy and commissions comprehensive wellbeing and preventative services in partnership with local authorities;
- puts quality at the heart of the NHS, getting the basics right every time, and gives the public information about the standard of quality achieved;
- works in partnership with staff, enabling them to lead and manage the organizations in which they work;
- integrates health and social care and offers new freedoms to consider social enterprise models;
- works within a constitution setting out rights and responsibilities.

Lord Darzi rightly identified nurses and midwives as key to achieving the report's central aim to deliver high quality care that is 'effective, safe and patient-centred'. Our Commission provides a timely opportunity to take this forward by offering a longer-term view of how future nurses and midwives could achieve this aim.

The general direction of travel was reinforced in *NHS 2010 – 2015: from good to great* (Department of Health 2009a). It says the NHS must respond to the six challenges faced by all modern health care systems: ever-higher patient expectations; an ageing society; the dawn of the information age; the changing nature of disease; advances in treatments; and a changing workforce. It sets out a five-year plan to reshape the NHS to meet the challenge of delivering cost-effective, high quality care in a tough financial environment, 'taking our improving NHS from good to great'. This advocates a stronger drive towards prevention and a more people-centred, productive service, and commits to 'providing the right training and skills to develop and to deliver care effectively, including investing in the development of leaders'. It envisages a health service organized around service users, whether at home, in a community setting or in hospital.

The future health system

To offer a nursing and midwifery perspective on this view of future health care, and to do justice to the future focus of our terms of reference, we developed a vision of nursing and midwifery in England over the next decade and beyond. Addressing many of the challenges mentioned above, we aimed to reinforce and where necessary accelerate existing policy directions, but also to add new thinking about how best nursing and midwifery could support service users, families, communities and the public in turbulent times – focusing throughout on achieving health and wellbeing for all and reducing inequalities.

Our thinking was strongly influenced by what we heard in our extensive engagement programme, including exciting ideas from many organizations and individuals, and we hope the vision described here will further inspire them and others. Later chapters will suggest some ways of moving from vision to action. We also built on recent government-commissioned work led by the National Nursing Research Unit (Maben et al. 2008). This envisages the registered nurses of tomorrow as practitioners, partners and leaders:

- skilled and respected frontline **practitioners** providing high quality care across a range of settings;
- vital and valued **partners** in the multidisciplinary team, coordinating resources and skill sets to ensure high quality care; and
- confident, effective **leaders** and champions of care quality with a powerful voice at all levels of the health care system.

We think the future health and social care system should be better integrated around service users, provide better support for self-care, and deliver more care closer to home, from before conception to the end of life. Service users and professionals should together develop care pathways based on maintaining health and wellness, using the best available evidence to define expected standards, ensuring the system remains focused on health outcomes and cost-effectiveness. Service users and their carers should be seen as integral members of their care team. They will be increasingly likely to hold a personal health budget and should be involved in planning their care and making decisions if they so choose.

The traditional barriers between hospital/home and health/social care should vanish, with communities served by integrated local networks of services driven by citizen and community engagement that deliver care through a wide range of agencies. Wherever possible these networks should be supported by electronic processes and communications, for example for easy access to clinical records, or remote monitoring of service users with long-term conditions. They will provide multiple entry points to the system, dispensing with the need for gatekeepers to manage supply and demand.

Grounded in community health, the network should include hospitals and other specialist services as integrated components of the health system rather than its apex. Hospital admissions should focus mainly on meeting two types of need: for complex and specialist care that cannot be safely or effectively provided in the community, and for expert nursing and midwifery care and observation. Nurses and midwives who continue to work mainly in hospital will be highly competent to meet these needs, but will also provide care outside the hospital when the service user's needs require it – just as community-based staff may continue to care for their patients during a hospital admission.

Individual care packages will be delivered by teams of practitioners who work flexibly in response to the needs of service users, families and the community. They should carry out a wider range of functions and roles, coordinated by a

lead provider who will often be a nurse. Rigid professional and organizational boundaries will vanish, and these interdependent, multidisciplinary, multi-agency teams will value mutual respect, co-production of health, and commitment to outcome and innovation. Advanced practice based on the best evidence will continue to transform roles and responsibilities. Practitioners will be empowered to use their resources effectively to reduce the burden and impact of disease, and assist effective navigation through the system. They will regularly conduct research, audit their work, learn from mistakes, and celebrate successes.

Practitioners and other professionals, in addition to detecting and managing disease in individuals, will develop their capacities to predict and prevent health risks. They will routinely contribute to community-based planning to address the local determinants of population health, aided by better public health data and analysis, population-based predictive modelling, and evidence on effective interventions.

Full information on health outcomes and service performance will be available to everyone. It will address indicators ranging from service user opinion and experience to clinical outcomes and expenditure. Increasingly, commissioners of services will use evidence of effectiveness and efficiency to determine investment priorities. This will lead to new models of care coordinated according to individuals' and families' biomedical and psychosocial needs.

Box 2.1.1 illustrates what some aspects of this vision might look like from a service user's viewpoint.

Box 2.1.1: Mary's care in 2020

Mary is an 87-year-old widow who lives in a self-contained bungalow in a retirement complex. She has severe osteoarthritis, Type II diabetes controlled by tablets, and Grade III heart failure. She has decided to hold the budget for her care, which gives her more control and choices. She has chosen to use a local care provider, a social enterprise joint venture by the neighbourhood Age Concern branch and the NHS community nursing service.

Mary accesses remote care via her digital television system. Every day she enters information about her pain levels, blood sugar and weight. The nurses who monitor the system then contact her or her care worker to advise on any changes needed in her care. These nurses have rapid and immediate access to advice from specialist nurses and other professionals. As a result of using this system, Mary has not needed a hospital admission for over two years.

The integrated team visits the retirement complex twice a week so that residents have quick and easy access to comprehensive care, and receive education on health and wellbeing and advice on income and benefits. Every few months Mary visits her sister, who lives over 200 miles away. The team helps her arrange this and provides her with a mobile monitoring device so they can continue to care for her wherever she is, funded by her personal budget.

Chapter 2.2
Our vision for nursing and midwifery

The shape of the future health system described in Chapter 2.1 has profound implications for nursing and midwifery. Building the human and social capital for care is one of the greatest challenges of our times. Nurses and midwives play a key role in determining the quality of health and social care and enabling people to make personal choices, and in public health, health promotion and illness prevention – crucial elements of future health care – but they cannot build this capital unaided. This is a major opportunity for them to deliver high quality care, be at the cutting edge of improvement and innovation, and be at the heart of planning, budget control, management and research. To do this they must be partnered and supported by the public, service users, carers, other health workers, employers, educators and policy-makers.

The six dimensions of our vision for nursing and midwifery are summarized below. In later chapters we address them in more detail and make recommendations on how they can be achieved. All will be rooted in a robust, ever-growing evidence base for policy and practice that scrutinizes public spending on nursing and midwifery through socioeconomic and clinical research and analysis. It will also examine benefits and costs to ensure rational policy responses and resource allocation and guide future action and investment in nursing and midwifery capital.

1 High quality, compassionate care

Our goal is that nurse and midwife clinicians will deliver and coordinate physical and psychosocial care for every service user, family and carer throughout their care pathway. Through getting to know service users – their needs, their preferences and their lives – the nurse or midwife will be able to help them obtain support to manage their conditions and maximize their quality of life, health and wellbeing. They will draw on a wide spectrum of attributes, knowledge and skills based on shared values and respect for human rights. These attributes will include an active and curious intellect, manual dexterity, familiarity with the evidence base for practice, critical judgement, creativity and psychological insight rooted in self-awareness.

Nurses and midwives working as clinicians, managers, leaders, teachers, researchers, scholars and policy-makers will enable and support the delivery of high quality care. Individual practitioners will welcome their acknowledged responsibility for care, and in return will be supported through the collective responsibility and actions of policy-makers, service commissioners, employers and managers. Nursing and midwifery roles and functions will be clearly described, understood and carried out, from point of care to board. Workplace cultures will create positive practice environments for delivering high quality care, providing development and support, and nurses and midwives will care better for others because they themselves are valued and cared for.

They will not provide care in isolation but in teams, including multidisciplinary ones, in which they will be valued as equal partners and sometimes leaders. Teams will have a balanced mix of skills, knowledge and attributes relevant to the communities they care for. They will adopt a new model of professionalism based on reflective practice; empowerment of patients and colleagues; interdependent decision processes; engagement rather than detachment; collective responsibility as well as individual accountability; and specificity of practitioners' strengths rather than interchangeability of practitioners (Davies 1996, Kendall 2003).

2 Health and wellbeing

Nurses and midwives play important roles in health promotion, disease prevention and maintaining health and wellbeing. In future all nursing and midwifery staff will think and act 'health' whenever and wherever they provide care, and be ever alert for health promotion opportunities – making wellness everyone's business. They will also be encouraged and supported to make healthy changes in their own lives.

Specialist community public health nurses will lead and deliver health promotion and illness prevention strategies; raise awareness and build greater expertise in public health; assess community health needs; tackle health inequalities and the social determinants of health through individual, group and community interventions; and ensure universal access to services. They will empower and train community members and carers to act as 'health change agents' and 'wellness coaches'.

Future public services will meet the needs of today without compromising the ability of future generations to meet their own needs. Nurses and midwives will act as green champions in hospitals and communities, working to make them more sustainable and environmentally friendly by reducing waste, cutting health-related carbon emissions, doing more with less, and promoting healthy and sustainable practices and lifestyles.

3 Caring for people with long-term conditions

Nurses' central role in the care and support of people with long-term conditions will be recognized and enhanced. They will lead, coordinate and deliver care, helping service users to minimize the impact of their condition, manage their own care, avoid further health problems and achieve the best possible quality of life.

Integrated care pathways will enable service users to be treated and cared for in community settings with minimal hospital admissions. Commissioning and payment frameworks will fully recognize all aspects of care related to maintaining independence, and nurses' potential contribution, enabling them to make full use of their existing legal and professional capacities and competencies, including rights of referral and discharge. Organizational structures with nurses in a central, coordinating role will be supported by single, efficient and generic recording systems, compatible with both health and social services and with common, compatible IT software.

4 Promoting innovation in nursing and midwifery

Nurses and midwives will work in new ways and sometimes in new roles in response to service users' needs. Radical shifts in service delivery and philosophy will provide important opportunities to increase their impact, and innovation will be a way of life, making and strengthening the connections between high quality care, cost-effectiveness and staff development. Supporting innovation and creating positive practice environments will occur in every setting with the right leadership and support, and will bring benefits to service users and staff.

Local empowerment will create local solutions. Nurses and midwives at all levels will be encouraged to think innovatively and influence system design and service delivery, in partnership with colleagues from industry and other sectors as well as health. Lessons will be learned from successes and failures. Research, development and evaluation will expand the evidence base for innovation, and best practice will be spread strategically to the mainstream.

5 Nurses and midwives leading services

Nurses and midwives will be confident and effective leaders and champions of care, with a powerful voice at all levels of the health system. The public, service users and colleagues will recognize and value nursing and midwifery leaders. The authority of clinical leaders in visible roles such as the ward sister, charge nurse and equivalent midwifery and community roles will be restored and enhanced.

There will be strong leadership at all levels, with those in senior management positions accountable for championing quality at all levels in their organizations, from the point of care to the board. Those already in leadership positions will support and encourage staff and inspire and nurture the next generation. Leaders will be appropriately prepared for their roles and equipped with clearly defined skills and competencies through a wide range of development programmes and fast-track schemes. Training in leadership skills will begin in initial education programmes and continue throughout the career pathway.

6 Careers in nursing and midwifery

Nursing and midwifery will be perceived as professions that offer worthwhile, engaging careers with high levels of responsibility and autonomy, and opportunities for personal and professional development and fulfilment. New stories of nursing and midwifery will be told, framed by a clear understanding of the lived reality of service users and the public in contemporary society as well as a comprehensive understanding of the professions. These stories will be used in effective and targeted national and local campaigns to educate the public, inspire the workforce, attract talented recruits from a wide pool reflecting the diversity of society itself, and promote nursing and midwifery as careers. They will capture the following elements and more:

- the diversity of the people who work in nursing and midwifery;
- the diversity of the settings where nurses and midwives work;
- nurses and midwives as members of a team of interdependent equals;
- working with head, hands and heart to deliver high quality, compassionate care; and
- nurses and midwives as health change agents.

Excellent recruitment and selection processes will attract people with the right aptitudes, values and potential. In future, to ensure high quality care, all newly registered nurses and midwives, together with many existing registrants, will be university graduates. The basic and continuing education of nurses and midwives will enable them to learn in new, creative ways, with optimum personal and professional development opportunities. They will develop high self-awareness that enables them to assimilate and practise the art and science of nursing and of midwifery and understand service users' needs. Many will use opportunities to study for master's degrees and doctorates to develop their capacities, expand the professions' evidence base and encourage innovative thinking and problem-solving.

Meeting the challenge

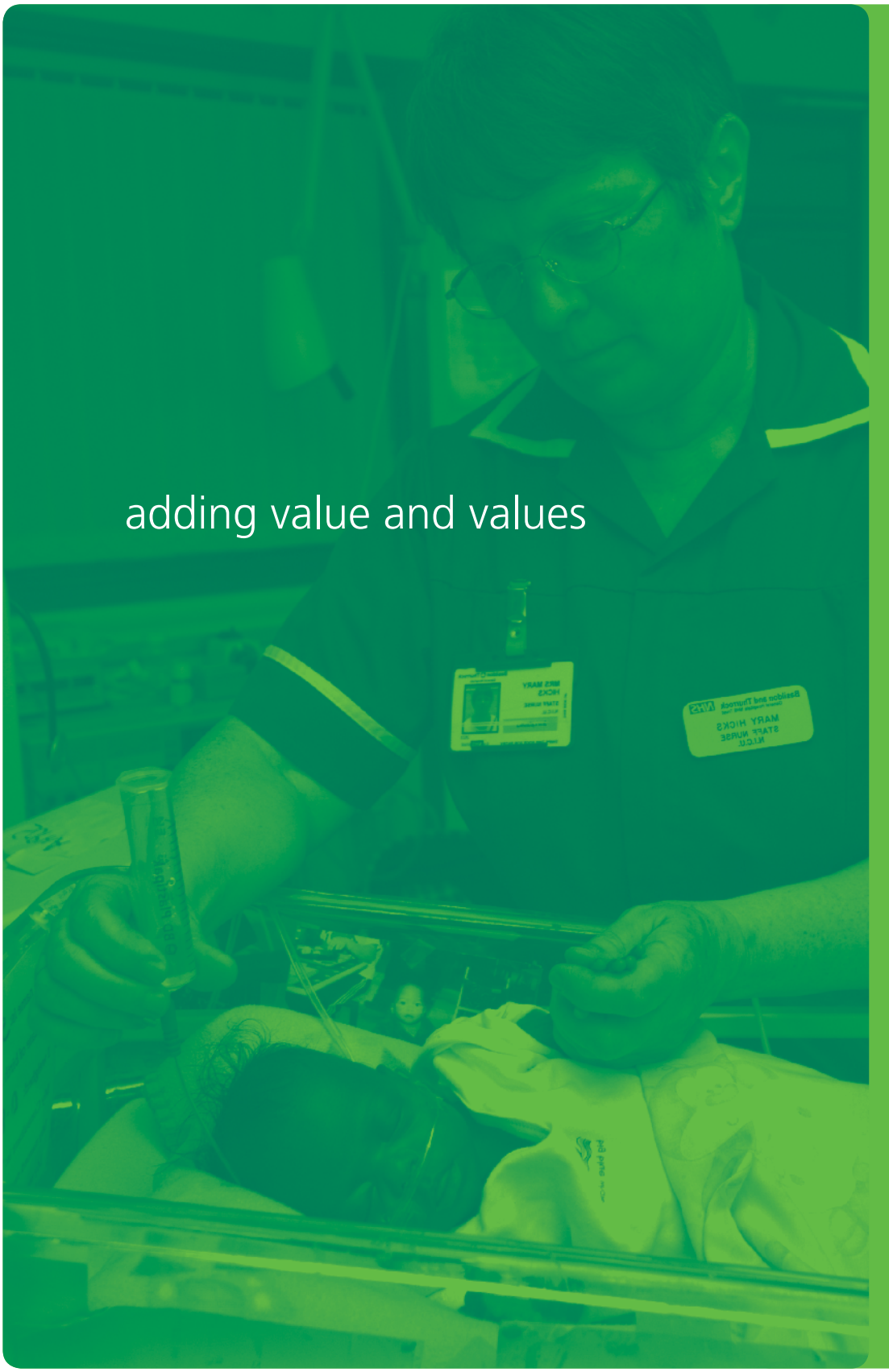
This, then, is our vision for nursing and midwifery. Much of what we would like to see is already happening, but is not universal. We need to go further, faster – but how well equipped are the professions to meet these challenges? This central question is explored in Part 3.

Part 3

Meeting the challenge

Chapter 3.1 **Nursing and midwifery today**
Chapter 3.2 **The political economy of nursing and midwifery**

adding value and values



Chapter 3.1
Nursing and midwifery today

We have described a challenging vision of the future health system and the contribution nurses and midwives could make to achieving it. Here we review how well equipped the professions are to meet those challenges.

The health system has always responded to changing pressures, though sometimes rather slowly, and nursing and midwifery have changed with it. As Box 3.1.1 shows, the practice of nursing has evolved continually since the NHS was founded, and now encompasses a wide range of roles and functions that would be unrecognizable to the nurses of 1948. Since the 1990s some nurses have acquired greater responsibility as autonomous and interdependent practitioners leading programmes of care, leading their own services and running their own clinics. Many are at the forefront of developing innovative roles and services, acquiring new skills, conducting clinical research and finding new ways to improve health and wellbeing.

Midwifery roles and functions, enshrined in statute since 1902, have changed much less dramatically. Midwives continue to provide the majority of care to most pregnant women at home, in community facilities and in hospital. They are autonomous practitioners able to lead their own services, make referrals, and supply and administer certain medicines. Innovative midwifery roles and functions are developing in response to public health concerns about vulnerable women – strengthening parenting skills, offering more choices about where and how women give birth, and providing more directly accessible services in non-traditional locations.

We found many examples of service user-centred care that indicate how best to tackle the challenges. The impressive achievements of the past decade, supported by the record numbers of nurses and midwives employed in the NHS, include increased capacity (reflected in a higher volume of activity) and intensity of care (reflected in shorter hospital stays). Here are a few examples of good practice among many highlighted during our engagement process:

- An ever-widening range of nurse consultants and others offer highly valued specialist expertise. Examples are Admiral nurses, who work with patients with dementia and their carers, and nurses who work with people with learning disabilities and their carers during general hospital admission.
- Emergency nurse practitioners lead many minor injuries units and are responsible for assessing, diagnosing and treating patients. These nurses, like many others, are able to prescribe medicines and make referrals to other specialists.
- Occupational health nurses provide pre-employment screening, identify and minimize workplace health and safety risks, and tackle and prevent work-induced injuries and stress.

Box 3.1.1: Nursing past and present

On the day the NHS was born – 5 July 1948 – nurses formed a guard of honour to welcome Labour health minister Aneurin Bevan to Trafford General Hospital, Manchester, for the formal launch of the NHS and a symbolic handover of the hospital keys. He described it as 'the most civilised step a country has ever taken', following years of war and socioeconomic deprivation.

A hospital stay then was measured in weeks rather than days or hours – or even years for elderly people and those with long-term conditions. Operations common today, such as joint replacements, were a thing of the future. Thousands of people died every year of infectious diseases such as pneumonia, meningitis and tuberculosis. There were no antibiotics – the recently discovered penicillin was not available for general use. The average life expectancy was just 66 years for men and 71 for women (in England it is now 78 for men and 82 for women).

Nursing was very different. Care was structured around a series of tasks, as likely to involve damp-dusting and scrubbing bedpans as bed-baths and taking temperatures. Female nurses wore starched uniforms more suggestive of domestic service than a profession; a complicated coding of belts, badges, caps and dresses denoted their strict hierarchy. Most male nurses worked in custodial roles in long-stay hospitals for people with mental illnesses and learning disabilities. Doctors directed many aspects of care, monitored by Sister and often by Matron.

The nurses who stood on the threshold of the NHS in 1948 had a clear, unshakeable understanding of their role. On our visit to Trafford General Hospital and Trafford Primary Care Trust, their successors told us what nursing today stood for and where it fell short. The caring relationship between nurse, service user and family was at the heart of nursing and must not be lost. They saw themselves as care coordinators and care managers, the 'common denominator' along the care pathway, conscious of their responsibilities to the rest of the team. 'There is a greater emphasis for us to be leaders. Our staff depend on us to set the standards of care that the patient deserves.'

In 1948 nurses trained in hospital schools of nursing and spent much of their time providing pairs of hands on the wards, rather than learning and practising under supervision. Today's Trafford nurses broadly welcomed the move to degree-level registration, feeling a graduate profession would do much to improve care and the image of nursing, as long as good recruits were selected that had 'a passion to care.'

- The award-winning team of nurses at the Defence Medicine Rehabilitation Centre, Headley Court, Surrey, uses innovative approaches to help servicemen and servicewomen to manage severe injuries and regain mobility. Other 'heroes behind the heroes' in the Defence Medical Services work at Selly Oak Hospital's centre of excellence, and Ministry of Defence hospital units, to nurse people with complex injuries sustained in overseas military operations.

- Nurses lead and deliver substance misuse services that help people to stop abusing drugs or alcohol, or change their risky behaviours through methadone programmes and needle exchange services.
- NHS Direct, the nurse-led telephone advice and triage service founded in 1998, receives nearly half a million calls a month. It has a user satisfaction rate of 94% (NHS Direct 2009).

Myths and misunderstandings

During our engagement programme we noticed low awareness of many of these developments in nursing, and considerable misunderstanding of current roles and responsibilities. Nursing innovations, it seemed, were a well-kept secret. A number of myths and misunderstandings about nursing, and sometimes about midwifery, persist among the public, service users, the mainstream media, other professions, and some front-line staff. As described 25 years ago, this state of affairs appears to have changed little: 'There is a huge gap between the ideas about who nurses are, what they do and where they do it, and the reality… a gap maintained by media misinformation. The images belittle nurses by describing them in stereotyped ways' (Salvage 1985).

The central role of midwifery in the delivery of maternity services was fairly well understood and appreciated. Most members of the public had an accurate sense of the midwife's role, often linked to personal or family experience of pregnancy and childbirth. Many, however, mistakenly thought the input of doctors was essential even in normal pregnancy, and did not grasp the full scope of midwifery practice.

Perceptions of nursing were mixed, and often fraught with misunderstanding. People who had encountered advanced practitioners appreciated their specialist expertise and ability to make decisions and referrals and prescribe medicines. The majority, however, still held a traditional view of nurses as poorly educated handmaidens to doctors, who might be kind and hard-working but had limited knowledge or skills to make decisions or influence outcomes. Many nurses felt some sectors of the media perpetuated these views.

Many respondents thought there had once been a golden age when service users received better personal care and nursing was always caring and compassionate. (There was little similar talk of midwifery.) While in no way belittling the real concerns of service users and the public about current care standards, we do not share this nostalgic view.

In reality the types of care and treatment available in the 'good old days' were much more limited, and service users had lower expectations and were deferential to professionals. Evidence-based practice, performance measurement, standards and protocols were in their infancy, except in maternity services where the audit concept was better developed. So-called Cinderella services such as long-stay care of the elderly, mental health and learning disability were based in asylums and

former workhouses where conditions and care were often substandard. Mortality and morbidity rates were much higher. The system was much less transparent and poor practice was often unrecognized, ignored or concealed.

Understanding nursing and midwifery

Understanding nursing and midwifery today requires a grasp of some baseline information. Most striking is the sheer size of the nursing and midwifery workforce, the key to its diversity. In 2009 there were over 625 000 registrations on the NMC register for England (these are registrations rather than individuals, as people may be registered on more than one part of the register). Nurses are the largest group of registered professionals in the NHS in England.

The NHS in England also employs many nursing and maternity support workers – non-registered staff who accept delegated tasks from registered staff. The precise number in different grades is not known, but in 2008 there were over 286 000 support staff to nurses, midwives and doctors in the NHS, including over 146 000 health care assistants. An unknown number of them are employed outside the NHS. Further statistics are given in Box 3.1.2 (NHS Information Centre 2009; NMC 2009).

Box 3.1.2: Key statistics on nursing and midwifery

- In 2009 there were nearly 595 000 RNs on the register residing in England, 77% of them registered in the adult nursing branch.
- In 2009 there were over 31 000 RMs on the register residing in England.
- Nine out of 10 of RNs in England are female.
- There are disproportionate numbers of men in more senior nursing positions and certain specialties: a third of mental health nurses, for example, are male.
- Nearly all RMs in England are female. There are 131 male midwives.
- Well over half the RNs and RMs working in the NHS in England (57%) are aged between 35 and 54, with less than 3% under 25. Almost 70% of RNs and RMs on the NMC register in England are aged 40 and over.

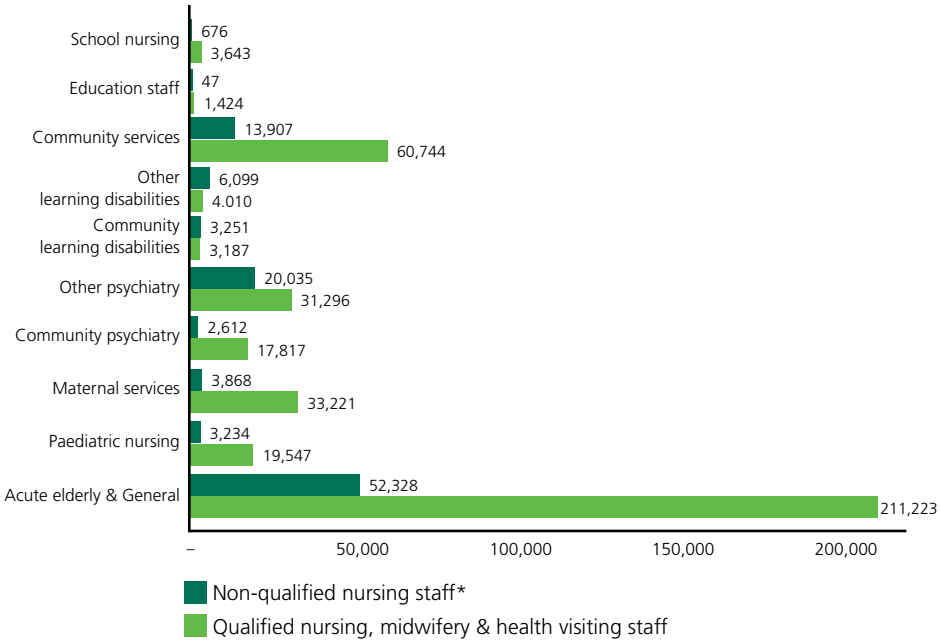
Here are some other key facts:

- Nursing and midwifery practice is regulated by the NMC. An independent body, it registers all nurses and midwives in the UK and all British military nurses and midwives anywhere in the world.
- Pre-registration nursing education prepares students to be admitted to the nursing register as a registered nurse (RN) in one of four branches – adult, child, mental health, or learning disability nursing. Degree and diploma programmes comprise 4600 hours, half practice, half theory, and usually take over three years.

- Pre-registration midwifery education prepares students to be admitted to the midwifery part of the register as registered midwives (RMs). Degree programmes usually take three years. Two-thirds of all RMs qualify through the direct entry route. RNs can take a 78-week course to become RMs.
- A third part of the register regulates specialist community public health nursing and is open to RNs or RMs who meet the required standards.

Most RMs and RNs (a total of over 386 000) work in NHS hospital and community health services in England. Figure 3.1.1 shows the composition of this workforce. A further 22 000 work in general practice. An estimated 200 000 RNs and RMs work in the independent and voluntary sectors; the armed forces; for other employers; as independent practitioners and consultants; overseas; or are not in employment.

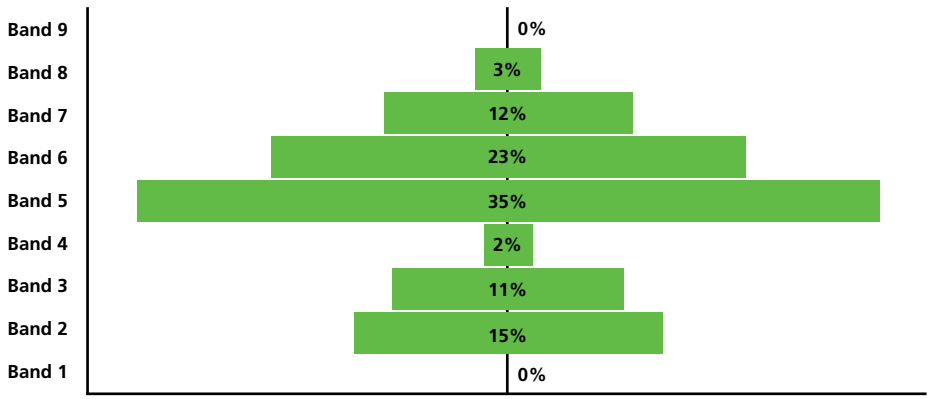
Figure 3.1.1: NHS nursing and midwifery staff in England by area of work (headcount) (NHS Information Centre 2008)



** Non qualified nursing staff comprise nursery nurse and nursing assistant/auxiliary*

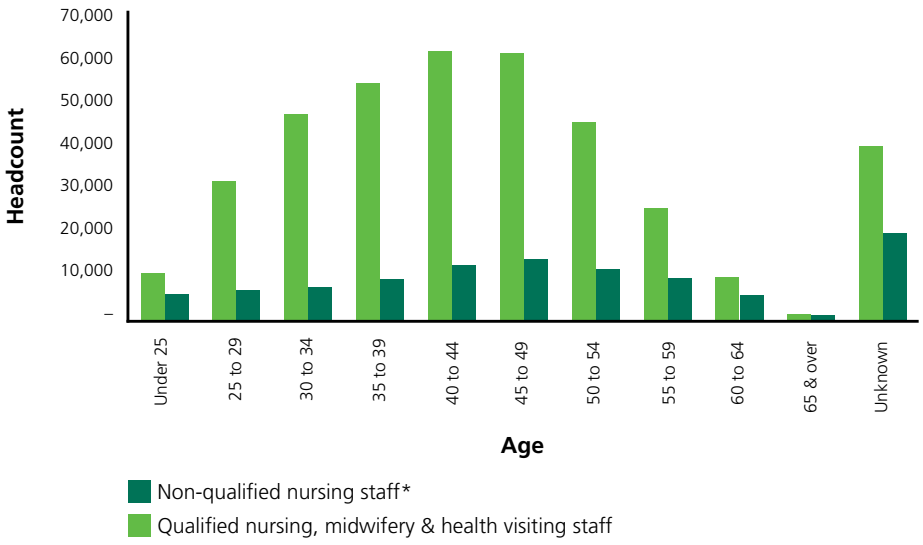
Agenda for Change, the most radical reform of the NHS pay system since 1948, was introduced in 2004. It covers over a million NHS staff across the UK, including the nursing and midwifery families, who are placed in one of nine pay bands 'on the basis of their knowledge, responsibilities, skills and effort needed for the job, rather than on the basis of their job title' (NHS Employers 2009a). Each post is assessed using the Job Evaluation Scheme, leading to the creation of national job profiles. For example, from the 2009 NHS national pay scales, associate (non-registered) practitioners are placed in Band 4 (range for basic annual salary £17 732 – £21 318); newly registered nurses and midwives enter at Band 5 (£20 710 – £26 839); and modern matrons are in Band 8a (£37 996 – £45 596). These figures exclude high cost area supplements and other additional payments. Figure 3.1.2 shows the percentage of nursing and midwifery staff in each band.

Figure 3.1.2: Percentages of NHS nursing and midwifery staff by Agenda for Change pay band, 2008 (headcount, excluding bank staff) (Department of Health data)



The nursing and midwifery workforce is ageing, a fact of crucial importance for recruitment, retention, workforce and service planning, and staff wellbeing. Figure 3.1.3 shows the age profile of NHS nursing and midwifery staff in England.

Figure 3.1.3: The age profile of NHS nursing and midwifery staff in England (NHS Information Centre 2008)



** Non qualified nursing staff comprise nursery nurse and nursing assistant/auxiliary*

Gaps in the evidence

Data collection and analysis on nursing and midwifery in England has improved in many respects and continues to do so, but there is still some way to go and there are many information gaps. For example, staff are often counted together in undifferentiated groupings that conceal their wide range of qualifications, grades, roles and salaries. Nurses and midwives are often counted and categorized together, as are registered and non-registered nursing staff. Disaggregated workforce statistics are generally available only for the NHS, and thus exclude the thousands of nurses and support workers in the independent and voluntary sectors, such as those working in care homes for elderly people. The collection and analysis of ethnicity data is weak.

Poor data hinder evidence-based policy-making and planning, such as workforce planning, and cost-effective care delivery. They also contribute to the sense of invisibility often mentioned by nurses and nursing and maternity support workers, and sometimes by midwives. This lack of precise information and other robust metrics – especially those that relate to health outcomes, which we discuss in the next chapter – contributes to myths and misunderstandings, and is an important barrier to change.

Chapter 3.2
The political economy of nursing and midwifery

Our terms of reference asked us to identify the competencies, skills and support that frontline nurses and midwives need to take a central role in the design and delivery of 21st century services. Our review of what we heard on this theme led us to conclude that there was a major gap in many stakeholders' understanding of nurses' and midwives' actual and potential contribution to health and health care. We concluded that the 'offer' of nursing and midwifery should be fully described, setting out where and how staff provide social, economic and environmental value in the delivery of health services, in order to make a stronger business case for investment in utilizing and enhancing their contribution.

Economic constraints underline the importance of identifying and measuring the nursing and midwifery contribution to society, health and care outcomes. These staff are an enormous human and financial resource, and making best use of them is a massive and complex undertaking. The substantial public spending on nursing and midwifery must be closely scrutinized through research and analysis that examines both benefits and costs, to ensure rational policy responses and resource allocation and guide future action and investment. At present the evidence base is thin, even threadbare in some respects.

Nursing and midwifery capital

Current social policy acknowledges the importance of demonstrating added social, economic and environmental value in the delivery of all publicly funded services. Further research and new approaches, such as the use of the Social Return on Investment framework to measure and account for social value, could help rectify the historical failure to fully identify and measure the nursing and midwifery contribution to health and care outcomes.

This is an opportune moment to set out where and how nursing and midwifery add value and values to the system and how their contribution might be enhanced. They add value in the economic sense, and also add the ethical and humanitarian values that underpin high quality care. This relates to our view of health as a value that generates socioeconomic benefits. To assist this analysis we wish to introduce the concepts of 'nursing capital' and 'midwifery capital'.

In classic economic theory, 'human capital' refers to the stock of skills and knowledge embodied in the ability to perform labour so as to produce economic value, including the skills and knowledge that a worker gains through education and experience. Nurses and midwives are paid to provide care and other services, for which the taxpayer makes a large investment. Nursing and midwifery capital is developed through their education and lifelong learning. It is used in their employment in health care, and elsewhere when they apply their skills and knowledge in a variety of other roles. Quantifying these other contributions

to society would create a more inclusive definition of nursing and midwifery capital, and thus a more comprehensive sense of the return they give on public investment. For example, in their private lives many act as carers and unpaid health advisers to their families, friends and communities.

At present the main quantifiable costs of nursing and midwifery comprise the NHS wage bill and pre-registration education. The estimated NHS wage bill for nurses, midwives and health visitors was over £12.1 billion in 2008-9. The costs associated with pre-registration training and support were estimated by the Department of Health as almost £1 billion, comprising over £568 million for tuition costs and over £352 million for bursaries.

This combined current annual spend of over £13 billion falls far short of the real total. A more accurate picture would include the wage bill of additional large numbers of staff working outside the NHS, and caring for NHS patients in nursing homes and other residential settings. It would also include continuing professional development and overall employment costs including national insurance and pensions. Such costs are hard to measure, but they are considerable because the nursing and midwifery workforce is so large, accounting for at least half of staff costs.

Assessing effectiveness

We wished to review existing work on cost-effectiveness, especially in non-acute settings where less research has been conducted despite their current and future importance. We therefore commissioned a rapid systematic review of reviews that focused on three areas of special interest: long-term conditions, mental health care, and role comparison (Caird et al. 2010). It drew on systematic reviews conducted in OECD countries with broadly comparable health systems and nursing/midwifery roles; 17 of the 32 reviews looked at studies from the UK. It only included studies where it could be ascertained what was being done and by whom, and to what other types of care nursing and midwifery was compared (no intervention, different models of nursing or midwifery care, or care from other health professionals).

Some key findings are shown in Box 3.2.1, including robust examples of the benefits of nursing in primary care; general practice-based nursing; specialist nursing; midwifery-led services; some inpatient care; and hospital at home. Crucially, given the current controversy about role and task substitution, nursing and midwifery care was not shown to produce adverse outcomes when compared with other types of care. Overall this makes a strong case for the comparative effectiveness of some nurse-led, midwifery-led and specialist nursing care.

Box 3.2.1: The cost-effectiveness of nursing and midwifery (Caird et al. 2010)

- Midwife-led care for low-risk women, compared to doctor-led care, appears to improve a range of maternal outcomes; reduce the number of procedures in labour; and increase satisfaction with care. There was no evidence of additional adverse outcomes associated with midwife-led care.
- Nurse-led inpatient units compared with doctor-led units show some evidence of benefit across outcomes including functional status, wellbeing, death or discharge to institutional care, and readmissions.
- Nurse-led care compared with doctor-led care appears to be beneficial for physical, satisfaction, and organizational outcomes in some types of cancer.
- Patient satisfaction may be higher with nurse-led primary care, when compared with doctor-led care. There was no clear evidence of a differential effect on any other outcome.
- There was no clear evidence of a differential effect on health status, patient satisfaction, quality of care, or resource use between nurses as first contact and providers of emergency care, and doctors.
- Secondary prevention care for heart disease provided by specialist nurses and general practice nurses, compared with GPs, was found to improve mortality, general health, diet, levels of exercise and angina symptoms. Other comparative benefits included increased follow-up and fewer hospital admissions.
- Specialist diabetes nurse care compared with doctor-delivered care may be beneficial for patients with poor diabetes control.
- Nurse therapists had a beneficial impact on clinical outcomes of patients with neurosis, compared with standard GP care.
- Targeted home visiting by health visitors and mental health nurses appeared to have a beneficial effect on postnatal depression.

Evaluation of midwifery

Our commissioned review found evidence of the benefits of midwifery in three systematic reviews conducted in the UK, Switzerland and the USA that compared midwife-led care during pregnancy and after birth with doctor-led care (Caird et al. 2010). No evidence of a difference between providers was found for infant outcomes. Midwife-led care demonstrated better maternal outcomes than doctor-led care with respect to pregnancy-induced hypertension, spontaneous vaginal birth and breastfeeding initiation, and less intervention, in terms of instrumental deliveries, episiotomies, use of analgesia and anaesthesia. Women receiving midwife-led care were less likely to experience antenatal hospitalization and fetal monitoring in labour.

Midwife-led care was beneficial in terms of service users' satisfaction and perception of care, and was more likely than doctor-led care to result in attendance at birth by a known midwife. There was no evidence of a difference between providers with respect to some other maternal outcomes and interventions, including Caesarean sections. The mean number of antenatal visits and duration of postnatal stay did not differ between providers. Other studies support this evidence that midwife-led care for low-risk women, when compared to doctor-led care, appears to improve a range of maternal outcomes, reduce the number of procedures in labour, and increase satisfaction with care.

The narrower scope and more specific expected outcomes of midwifery make its socioeconomic case easier to construct. The challenge is not to analyse what midwives can contribute, but to ensure their resource is properly used. At present, for example, there is some wasteful duplication between midwife and GP, and midwife and obstetrician. The midwifery 'offer' has not changed and the midwife should work at all times in the way she is enabled to in statute and through education; otherwise society is not getting best value for money.

Other evidence

Stakeholders gave us many other examples from a growing body of evidence that nurses and midwives save lives, improve health and quality of life, provide high quality care, improve the care process, and contribute to the wider economy. For example, a recent study demonstrated that the best staffed UK NHS trusts had significantly lower patient mortality rates than the least well staffed trusts, and the best staffed wards had significantly lower levels of burnout and exhaustion and higher levels of job satisfaction (Rafferty et al. 2007).

The cost issues are less clear. Suitable data to assess cost-effectiveness are not available in many studies, especially for comparing the economics of substitution or enhanced practice. Few studies of cost-effectiveness or cost-benefit analysis of nursing and midwifery have been conducted in England or indeed worldwide, reflecting not only the absence of data, but also the lack of policy focus and research support and investment.

The existing evidence base is not widely enough known, and its implications for improving cost-effectiveness are not fully heard or heeded by the public, policy-makers, decision-makers and fellow professionals, or indeed by some nurses and midwives. The findings of our review highlight the need for a great deal more work of this type commensurate with the large public investment in nursing and midwifery, and for a much greater focus on dissemination of research and action on its implications.

Research and development programmes at all levels should have an appropriate focus on nursing and midwifery. A national data bank could review and disseminate such research and establish priorities. We also propose more extensive research programmes focusing on assessing and improving on the cost-effectiveness and cost-benefits of nursing and midwifery, with funding that reflects the large public investment in them.

These programmes should focus on outcomes; productivity; improving service users' experiences; the staff numbers and skill mix needed to provide safe, effective care; and areas such as mental health, learning disabilities and long-term care and conditions, where little research has been conducted on nursing interventions. Such research should link with wider research and development programmes in health care. Multidisciplinary studies are also needed to assess the comparative effectiveness of interventions by different team members.

Measuring progress and outcomes

Good metrics are essential for better evaluation of nursing and midwifery. 'Accurate and meaningful outcome measures for nursing (metrics) are central to the specific changes proposed to promote a new focus on quality,' said a report commissioned to support the Next Stage Review (Griffiths et al. 2008). Yet at present there is no comprehensive approach to enable benchmarking across and between organizations.

More attention should be paid to the nursing element of current measures of quality. The development of a framework of explicit, nationally agreed indicators for nursing, including key performance indicators such as patient-related outcomes, should be accelerated. It should scale up the use of benchmarking tools such as the Essence of Care (Department of Health 2001). It should also contribute to sustaining high quality, compassionate care by clarifying what service users can expect; making explicit the responsibilities of nurses in the health care team; and improving the commissioning and evaluation of nursing services.

A set of nursing indicators should be identified for inclusion in the evolving 'clinical dashboard' that can quantify trends and characteristics; describe performance in achieving health service goals, especially those elements to which nursing strongly contributes; and provide information to improve care (Griffiths et al. 2008). These approaches must be taken forward speedily, as a major dimension of comprehensive, multidisciplinary metrics – we agree with Lord Darzi on the need to identify indicators that measure the work of the clinical team (Staines 2009).

Success will depend on actively engaging front-line nursing and midwifery staff in achieving best value, and developing their appreciation of the skills required for assessing the economics of care. This is much more likely to happen in settings where they are valued and leadership is strong. We heard many complaints about paperwork and data collection taking time away from care. We agree with the RCN and others that clinical nurses should champion the development of better metrics, and help to design user-friendly systems that measure the right things in the right way; collect evidence of patient-related outcomes and provide rapid feedback to practitioners and service users; have expert advice on tap; and use appropriate, time-saving metrics technology.

Progress appears better in maternity services, where the concept of a clinical dashboard is widely accepted. Most of the indicators are not midwifery-specific but are very relevant to midwifery, including activity and staffing. Qualitative data such as patient-related outcomes are an important element of most maternity dashboards. Further work is needed to identify midwifery performance indicators that have the biggest impact on outcomes and service user satisfaction.

Releasing time to care

Making best use of nurses and midwives requires clarity about how they should spend their time and what tasks can safely be delegated to less skilled staff. One nurse turned trust chief executive said it meant having 'absolute clarity about what we are doing and why'. The NHS Institute for Improvement and Innovation says nurses spend less than 40% of their time on direct patient care, and some studies put the figure far lower. 'Hunting and gathering' to find equipment or linen, chasing test results and non-nursing tasks were all cited to us as ways in which nursing and midwifery capital is misused and underused.

The loudest message we heard from the public, service users and staff was that there were too few nurses and midwives and they did not have enough time to care. Typical concerns included 'being able to dedicate more time to caring and actually knowing their patients'. Most respondents related these issues to resource constraints, and many practitioners and their organizations translated them into a simple demand to increase nursing and midwifery numbers. We underline the immense importance of effective recruitment, retention and return in maintaining staff supply, and commend the steps being taken to address the shortages of midwives and health visitors.

Some research suggests practitioners do not always want to spend more time with service users, or are not encouraged to. The reasons include the structures in which they work, the perceived low status of essential care, the need to 'get the work done', and the stress of emotional labour. These issues should be acknowledged and acted on to increase workforce capacity and satisfaction.

Initiatives that explore how to optimize skills, improve flow and reduce waste to 'do more with less', such as the *Productive series* (NHS Institute for Improvement and Innovation 2010), are producing excellent results. Time will be also be released to care if all clinicians ensure their interventions are based on best practice, stop giving treatment and care if its effectiveness is not proven, and end over-treatment and unnecessary procedures. For example, nurse prescribers are achieving better adherence to drug regimes and reducing overprescribing. Nurses, midwives and other professionals need to be supported in challenging each other to deliver evidence-based care.

Recommendations

Evaluating nursing and midwifery

Gaps in the evidence base for the evaluation of nursing and midwifery must be clearly identified to determine what further research is needed, and further steps taken to commission, fund, disseminate and utilise research on their social, economic and clinical effectiveness.

Measuring progress and outcomes

The development of a framework of explicit, nationally agreed indicators for nursing must be accelerated, with the full engagement of front-line nurses. Further work must be done in midwifery to identify better indicators of outcomes including service user satisfaction.

Part 4

The way forward

Chapter 4.1 **High quality, compassionate care**
Chapter 4.2 **Health and wellbeing**
Chapter 4.3 **Caring for people with long-term conditions**
Chapter 4.4 **Promoting innovation in nursing and midwifery**
Chapter 4.5 **Nurses and midwives leading services**
Chapter 4.6 **Careers in nursing and midwifery**

our promise to society

Enabling high quality care

So far we have assessed current trends in health and health care, the policy responses, and the current state of nursing and midwifery. We responded to our terms of reference by creating a vision to shape nursing and midwifery in England over the next decade and beyond. Now we turn to the way forward, building on what has gone before and outlining what needs to happen to achieve our vision and fulfil the health-creating, socioeconomic potential of nursing and midwifery.

Our headline concern is how best to enable nurses and midwives to deliver high quality, compassionate care. We heard that such care has many different drivers. They include sustaining the values that underpin high quality care; ensuring public protection; evidence-based practice that focuses on health and wellbeing; setting standards, reviewing how well they are met, and acting on the findings; wise leadership; workplace cultures that facilitate good teamwork, innovation and time to care; and good workforce recruitment, preparation, development and deployment.

These issues are explored in the chapters that follow. First, however, we propose a new pledge as an overarching nursing and midwifery commitment to delivering high quality care. Then, mindful of our terms of reference and our mandate to look into the longer-term future, we propose 20 high-level recommendations on six major themes:

1 **High quality, compassionate care:** we explore the challenges and opportunities facing nurses and midwives delivering care, and the knowledge, skills and attitudes required to deliver high quality care in future.

2 **Health and wellbeing:** we highlight the future role of nurses and midwives in designing and delivering services to promote health and wellbeing and reduce inequalities, and the support that nurses and midwives need to maintain their own health and wellbeing.

3 **Caring for people with long-term conditions:** we highlight the future role of nurses in designing and delivering services to promote and maintain health and wellbeing for people with long-term conditions.

4 **Promoting innovation:** we identify the potential for promoting and supporting nursing and midwifery innovation, and removing the barriers so that it can become a way of life.

5 **Nurses and midwives leading services:** we identify the potential and benefits for nurses and midwives of leading and managing their own services, particularly in primary health care and community care, and the linchpin roles of the ward sister and equivalent roles in hospital and community.

6 **Careers in nursing and midwifery:** we outline the preparation that nurses and midwives will need to work effectively in the future health system, workforce challenges and opportunities, and the need to tell new stories of nursing and midwifery.

Achieving our vision for the future requires a strong ethical base to drive personal, professional and organizational commitment to making a difference. We heard complaints that important values were sometimes neglected in modern society and health care, and that there should be a revival of respect, compassion and social cohesion. Enshrined in the NHS Constitution and the professional codes by which all nurses and midwives should set their moral compass, these underpin our vision of high quality care.

The NHS Constitution, which establishes the principles and values of the NHS in England, applies directly to all services funded or commissioned by the NHS, and all staff in these services are required to uphold it (Box 4.1) (Department of Health 2009b). We wish to underline its significance in creating a renewed sense of civic responsibility and providing guidance on handling the impact of economic pressures on health services.

Box 4.1: The NHS Constitution

The NHS Constitution sets out rights to which patients, public and staff are entitled; pledges that the NHS is committed to achieving; and responsibilities that the public, patients and staff owe each other to ensure the service operates fairly and effectively.

The guiding principles of the NHS are underpinned by core values derived from extensive discussions with staff, patients and public. These values are:

- respect and dignity
- commitment to quality of care
- compassion
- improving lives
- working together for patients
- everyone counts.

Professionals also agree to abide by ethical rules in return for the trust vested in them by those whom they serve. The national and international professional and regulatory bodies for nursing and midwifery have developed codes based on values of respect for human rights and commitment to social justice, including cultural rights and the right to life and choice, to dignity and to be treated with respect (International Confederation of Midwives 2003, International Council of Nurses 2006).

All nurses and midwives in England are required to adhere to the code produced by their professional regulator, the NMC (Box 4.2) (NMC 2008). Additionally, the midwifery rules and standards set out what the public has a right to expect from a person practising as a midwife, and similar frameworks for the branches of nursing underpin standards and curricula.

Box 4.2: From the NMC Code

'The people in your care must be able to trust you with their health and wellbeing. To justify that trust, you must:

- make the care of people your first concern, treating them as individuals and respecting their dignity;
- work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community;
- provide a high standard of practice and care at all times;
- be open and honest, act with integrity and uphold the reputation of your profession.'

The NHS Constitution, the international professional codes, and the standards and rules set by the NMC and other regulators such as the Care Quality Commission together comprise a comprehensive guide to conduct and performance that addresses most of the concerns we heard from service users and the public. New ways must continually be found to refresh awareness, understanding and adherence, as advocated by the NMC Code Champions.

Public trust has been undermined by recent examples of poor practice, and we believe a strong statement of commitment would help to restore it. Many service users and staff said they wanted a new beginning – as one nurse from Trafford Hospital put it, it was time to 'remind nurses of the pledge they made when they qualified and received their badges'. We therefore propose that all nurses and midwives renew their promise to society and service users in a public pledge to deliver high quality care.

The pledge is a set of commitments that aim to strengthen public trust and confidence in nursing and midwifery. It recognizes service users as partners and co-producers of their own health and wellbeing, and responds to their entitlement to greater choice and participation in decision-making, as their mental capacity permits. It states how nurses and midwives will maintain and enact their values to deliver high quality care.

The pledge is relevant at three levels. Nationally, through the collective leadership of nursing and midwifery leaders, the professions can renew their 'promise to society'. Locally, nurses and midwives can work closely with service users to reach a shared understanding of what high quality care means in that locality or setting. Individually, nurses and midwives can clarify their values and care entitlements and agree with service users what should happen if standards are not attained.

We propose a model pledge that can be used as it stands or adapted for different purposes. Nurses and midwives should consider how to use it in their own work settings. Regulators, employers and education providers should use it to review their current codes, advice and guidance on nursing and midwifery. They must deliver their side of the bargain and ensure that nurses and midwives receive active support and protection to enable them to fulfil it.

The nursing and midwifery pledge to deliver high quality care

1 Every nurse and midwife will uphold the Nursing and Midwifery Council Code and the values of the NHS Constitution, wherever they work, and will accept responsibility for and take charge of the quality of care, service and outcomes for every service user in their care. Each one of us will speak out and act wherever and whenever care falls below the agreed standard.

2 Every nurse and midwife, acknowledging the huge public investment in the provision of health care in the NHS and elsewhere, will act to ensure that these resources are used to optimum effect for the benefit of service users and society. This includes making best use of our own time and expertise, and developing and adopting practices, services and lifestyles that are health-promoting and sustainable.

3 Nurses and midwives, recognizing our important role in improving health and wellbeing and reducing inequalities, will engage actively in the design, monitoring and delivery of services to achieve this. We acknowledge that we are seen as role models of healthy living and will try to live up to this responsibility.

4 Nurses and midwives, acknowledging the public investment in our education, training and continuing professional development, will commit to delivering care that is evidence-based and effective, and evaluating and researching it to expand our knowledge of what works best.

5 Nurses and midwives, acknowledging that we are responsible for ensuring that health care decisions are informed by our expertise, will engage more directly with policy-making and decision-making. This includes decisions on funding priorities, health care technologies, and the development of innovative models of care.

6 Nurses and midwives will lead and manage the delivery of high quality, compassionate care. We will be at the leading edge of innovation, always challenging the status quo and taking responsibility for creating new solutions.

Chapter 4.1
High quality, compassionate care

High quality care: our call to action
Variations in standards of care are unacceptably wide. Nurses and midwives should renew their promise to society and service users and become the champions of high quality care. Meeting people's needs in a compassionate way requires the highest levels of skill and professionalism. To achieve this, significant changes are needed in the organizations and teams in which practitioners work, ensuring that the nursing and midwifery voice is heard at every level and helping to eliminate the individual and system failures that underlie poor quality care. Work processes should be streamlined to ensure enough time is spent at the point of care. The public can be further protected through ensuring that skill and grade mix will deliver high quality care; regulating advanced practice; regulating nursing and maternity support workers; and standardizing roles and job titles.

Tackling poor care – everyone's responsibility

We heard and saw many fine examples of nursing and midwifery practice and leadership, but individual experiences and a recent stream of high profile failures have highlighted examples of poor nursing and midwifery care in many different settings. We deplore these unacceptable variations in standards. Achieving high quality care must rise to the top of the agenda, with public protection as the starting point. Health policy, management, education and regulation should be reviewed to ensure they provide the infrastructures and cultures that enable nurses and midwives to deliver high quality care.

We also heard complaints about some nursing and midwifery staff lacking confidence or willingness to blow the whistle on poor practice. Front-line nurses and midwives should be visible guardians of quality and safety, and take control of the supervision and monitoring of care within and across teams and throughout the care pathway. All directors of nursing, heads of midwifery and other nurses and midwives in senior management roles should accept individual managerial and professional accountability for ensuring that their organization provides high quality care. They must have the necessary clinical competence and awareness.

Some health service leaders and boards have failed to consider fully the 'business of caring' (Burdett Trust for Nursing 2006). Recent inquiries powerfully illustrate the tragic consequences of such failure (Healthcare Commission 2006, 2007, 2008, 2009). It is unacceptable: as the 2010-2011 NHS Operating Framework states, 'it is the responsibility of each and every board to assure itself that the services it provides are safe and of high quality' (Department of Health 2009c).

NHS policy-makers, planners and decision-makers are therefore required to ensure they mainstream care and quality issues. The boards of NHS trusts and other health providers must create environments in which governance and decision-making are transparent and permissive, concerns about care are taken seriously, and nurses and midwives are encouraged to voice concerns and suggestions. To put quality at the centre of care, nurses and midwives must be at the centre of policy.

Commissioning of services will be an increasingly important driver of quality. Commissioners must ensure they secure nursing and midwifery advice and leadership, especially at board and senior levels, and nursing and midwifery leaders should actively advocate care perspectives. Funding mechanisms should not favour the acute sector and traditional models of care over community-based approaches and innovation. They should be more sensitive to the softer aspects of care, and adopt the concept of pathways rather than episodes of care. A level playing field should be created for all professionals wishing to tender for services.

We heard that some workplace cultures were good, but that others had some way to go. Investigations of poor performance often reveal that individuals or groups of nurses or midwives were working in organizations, departments or teams that did not listen to them, support them or reward them. We were reminded many times of the effectiveness of cultures where recognition and praise for good practice and a job well done is the rule, not the exception. Feeling valued and involved is the strongest driver of staff engagement and generates a sense of ownership, pride and commitment. As a participant in our NHS East of England event told us: 'Recognition is needed at all levels, individual, team and national.'

Health organizations should be open to challenges from colleagues and service users, scrutinize the whole system for weaknesses when untoward incidents occur, learn from mistakes, and focus on improvement rather than blame. They should value diversity and humanity, and have zero tolerance for hierarchical behaviours, discrimination, harassment and bullying. Employers, managers and leaders should consider how they can engage staff fully in improving standards and services – ensuring regular, fully funded opportunities for professional development, and the means to be healthy and satisfied in their work.

Workforce redesign and public protection

We recognize that nursing and midwifery staff cannot be protected from the challenging times ahead, but should rather be in the vanguard of change. Directors of nursing and heads of midwifery are best placed to lead the necessary nursing and midwifery workforce developments. If nursing and midwifery leaders are to uphold the pledge and be fully accountable for the quality of nursing and midwifery care, they must also be given the authority to manage and shape that workforce.

The implications for future workforce design of the move to degree-level registration of all new nurses in England should be clarified. We envisage a 'new nursing world' where future roles and pathways are recast and rebalanced to correlate with the rising demand for nursing interventions (RCN 2009b). The new cadre of all-graduate RNs should provide linchpin clinical leadership, coordinate and closely supervise care delivery, and deliver some complex care.

Rapid, locally-driven modifications in the shape and functions of the nursing and midwifery workforce are already under way, including new roles, role substitution, and delegation of tasks and responsibilities. These may be valuable innovations, but they raise serious concerns about public protection when poorly implemented and not monitored or evaluated. As the RCN and UNISON told us, skill mix reviews to help organizations have the right staff with the right skills in the right place at the right time should always be quality-driven. Regulation and education are struggling to keep pace with these changes.

We were told that poor practice often occurred because staff were acting beyond their level of competence. Particular concerns related to the proliferation of nursing roles and titles, advanced nursing practice, and health care support workers.

1 The proliferation of roles and titles

Roles continue to diversify and develop in nursing, and to a lesser extent in midwifery. This sometimes creates confusion. We heard from the public and other stakeholders, especially doctors, that they were often unclear about what skills and competencies they could expect from individual nurses and support workers, exacerbated by the plethora of job titles and role descriptions. 'The public is confused about what a nurse is. Even among ourselves we're confused,' nurses told us in Yorkshire and the Humber.

We heard a number of solutions: simplify and reduce the number of job titles; introduce clearer dress codes; make sure that service users are better informed; and ensure all staff always introduce themselves properly and explain their role. 'We need to engage proactively with patients and introduce ourselves, our role, who we are and what we do,' said a professional from NHS South Central. Stakeholders should consider how to reduce and standardize the proliferation of job titles in nursing.

'Anyone can call themselves a nurse and this is wrong. We seem to have lost our identity and what makes us what we are,' nurses at Trafford Healthcare NHS Trust told us. We believe the title 'nurse' requires full protection, to ensure public safety and to allay current confusion about roles, titles and responsibilities. Its use should be limited to nurses registered by the NMC. The title 'midwife' is already protected.

2 Advanced nursing practice

The proliferation of roles and titles is linked with other concerns around public protection, especially in relation to advanced practice roles in nursing. Many of these have evolved locally, and there is little consistency in terms of job content, title, scope of practice or credentials. Progress towards the regulation of advanced practice has long been debated, internationally as well as in England, and appears to have stalled (Hinchliff and Rogers 2008). We share the NMC's concern that the public is not adequately protected while this issue remains unresolved. We encourage collaboration by all stakeholders to provide better public protection and reassurance, including consideration of minimum qualifications for advanced practitioner roles. We fully support the NMC's intention to address it in accordance with Article 22 of the Nursing and Midwifery Order 2001 (Stationery Office 2002).

The impact of advanced practice and other forms of role extension should not be considered in isolation. The British Medical Association, for example, while broadly welcoming extended roles that realised 'the full potential of nursing and midwifery skills', told us that any proposals to extend current roles should take into account the roles and responsibilities of other health care professionals.

3 Health care support workers

NHS employers told us that the move to degree-level registration was likely to stimulate employers to make more use of assistant practitioners, i.e. nursing and maternity support workers who are not RNs or RMs (NHS Employers 2009b). Some trusts are already introducing more responsible assistant practitioner roles for staff in Agenda for Change band 4, and for other support workers in bands 1-4. These roles and functions are very varied and, we were told, poorly defined and lacking consistency across employers.

Midwives advised us that the scope for an assistant practitioner role was limited in maternity services, except in areas like theatres and recovery. 'Midwives should be doing midwifery. The trend to replace midwives in areas where it is nursing skills that are needed, such as theatres, should be accelerated to release midwives into the system,' the RCM told us. Maternity support workers may work at band 4 but only in appropriately delegated roles; otherwise there are risks to women.

Training opportunities need to keep pace with this rapid expansion in support worker roles and numbers. We were told that training of health care assistants varies greatly, trust by trust, in London: 'There should be more standardization of education.' In the East of England we were told, 'There are a lot of support workers who are hungry for education and training, but they can't get on a course.' UNISON advocated a national competency framework for health care assistants and other support workers to end inconsistencies in standards, roles and responsibilities, and is developing work to take this forward.

We welcome policy commitments to develop educational and employment models that widen access to nursing and midwifery education and provide meaningful career pathways for support staff in bands 1-4, including those who wish to train as nurses or midwives – over half the health care assistants in a recent survey (UNISON 2008). Given the large amount of direct care that support workers provide, and the rapid growth in numbers, we believe the public would be better protected through some form of regulation of staff to whom nurses and midwives delegate tasks. There are precedents: the General Dental Council, the General Optical Council and the Royal Pharmaceutical Society of Great Britain regulate assistant practitioners.

We heard different views about whether and what kind of regulation is needed, be it registration, licensing or other mechanisms. A more structured and comprehensive approach has benefits but a burdensome regime must be avoided. We therefore welcome the NMC's decision to commission research on the potential risks and benefits of regulating support workers, and its intention to use this research to scope the options for regulating health care assistants and assistant practitioners. Urgent decisions should then be made, to protect the public and ensure high quality care.

Compassionate care is competent care

Service users and the public told us that above all else they wanted nurses and midwives to be caring and compassionate, and to spend more time with them. They wanted physical and psychological care and emotional support, and to discuss how they could best manage their conditions. In the NHS Constitution, compassion is one of the core values that underpins the guiding principles of the NHS. As Portsmouth Hospitals NHS Trust proposed to us, we want a future where patients, relatives and carers are at the centre of service development and design; 'compassionate care delivered by technically competent nurses and midwives who maintain a person's dignity is regularly fed back as being the key to a positive patient experience.'

Many problems arise from the absence of sufficient or appropriate communication – as one patient told us, 'When I was in hospital no-one seemed to think that I needed to be told very much', an unacceptable state of affairs. Black and minority ethnic service users and people in seldom-heard groups described communication problems, stereotyping and judgemental care; some nurses and midwives must work harder to uphold the NHS Constitution statement that 'everyone counts'. A midwife spoke of treating women as intelligent equals and not as a number: 'Explain everything as it happens, and tell women what to expect, so they are not scared or unduly worried.'

Meeting a service user's complex needs in a compassionate way requires the highest levels of professionalism. It is not just about being a nice person, or the stereotypical caring but submissive, poorly educated nurse. Compassion alone is not enough: a nurse or midwife who is compassionate but lacks competence cannot give high quality care. To care with compassion, nurses and midwives must work with their heads, hands and hearts.

'Nursing is more than the sum of its parts. Any health system needs nurses who are intellectually able and emotionally aware and who can combine technical clinical skills with a deep understanding and ability to care, as one human to another,' said Christine Beasley, England's Chief Nursing Officer (Department of Health 2006). 'This is a constant of nursing. It is the value base on which public trust rests and the profession is grounded. As a profession it is our promise to society,' she said. Her comments apply equally well to midwifery.

This comprehensive understanding of 'care' reflects the description of high quality care as 'effective, safe and patient-centred' in *High Quality Care for All* (Department of Health 2008). We wish to widen it to encompass all the other ways nurses and midwives care. These include challenging bad practice; tackling health inequalities at individual, community and societal levels; fighting for social justice; challenging discrimination and stigma; and promoting health and wellbeing. To deliver such care requires not only individual commitment from every nurse and midwife, but also commitment and action from policy-makers and health service leaders to create the infrastructure that enables them to care.

Recommendations

A pledge to deliver high quality care

Nurses and midwives must declare their commitment to society and service users in a pledge to give high quality care to all and tackle unacceptable variations in standards. The pledge complements the NMC Code, the NHS Constitution and other professional codes and regulatory standards. Nurses and midwives must use it to guide their practice, adapting it to their work settings, and regulators and employers must ensure that their codes, policies and guidance on nursing and midwifery support it.

Senior nurses' and midwives' responsibility for care

All directors of nursing, heads of midwifery and other nurses and midwives in senior management roles must uphold the pledge, accept full individual managerial and professional accountability for the quality of nursing and midwifery care, and champion care from the point of care to the board. Directors of nursing must maintain clinical credibility and act with authority to ensure that their organizations enable high quality care. As board members they must be accountable for agreeing the shape and size of the nursing and midwifery workforce.

Corporate responsibility for care

The boards of NHS trusts and other health employers must accept full accountability for commissioning and delivering high quality care, ensure clear lines of accountability and authority for care throughout their organizations, and appoint a director of nursing to champion care at board level. They must ensure that their cultures and structures recognize and support directors of nursing and senior nurses and midwives to execute their responsibilities fully in relation to quality and safety.

Protecting the title 'nurse'
The Nursing and Midwifery Council must take urgent steps to ensure public protection and safety and to allay current confusion about roles, titles and responsibilities by protecting the title 'nurse' and limiting its use solely to nurses registered by the Council.

Regulating advanced nursing and midwifery practice
The Nursing and Midwifery Council must regulate advanced nursing practice, ensuring that advanced practitioners are recorded as such on the register and have the required competencies. Stakeholders must also consider how to reduce and standardize the proliferation of roles and job titles in nursing. The Midwifery 2020 programme should consider whether midwives working in specialist and consultant roles need advanced level regulation.

Regulating nursing and midwifery support workers
Some form of regulation of non-registered nursing and midwifery staff, including health care assistants and assistant practitioners, must be introduced to protect the public and ensure high quality care. The government and stakeholders must urgently scope and review the options, and recommend what type and level of regulation are needed.

Chapter 4.2
Health and wellbeing

Health and wellbeing: our call to action

All nurses and midwives should think and act 'health' whenever and wherever they provide care, and be ever alert for health promotion and illness prevention opportunities – making wellness everyone's business. They should play a bigger part in promoting health and wellbeing, preventing ill health, and reducing health inequalities. This involves working with well people and ill people, finding the best balance between biomedical, psychosocial and public health approaches, and addressing the individual, social and environmental sources of ill health. They should make hospitals and communities more sustainable and environmentally friendly by promoting healthy and sustainable practices and lifestyles, as well as caring for themselves and trying to be healthy role models. Specialist community public health nurses should take the lead in developing and delivering health promotion and illness prevention strategies.

Reduction of inequalities and further improvements in population health and longevity will depend on creating health-supporting environments and making healthy choices easier choices, including universal access to health promotion, disease prevention and health services. Prevention is better than cure, for social and economic reasons. Biomedical interventions such as medication and surgery should be complemented by stronger social and psychological approaches (Wilkinson and Marmot 2003).

We found strong consensus among public and professionals on the need for nurses and midwives to focus more on health promotion and illness prevention. This will help them to meet future health needs, while building on important recent progress. People in England live longer and are generally much healthier than ever before, including the poorest citizens. Health inequalities are growing, however, so the challenge is levelling up to reduce disparities in the relative health of individuals and communities and in their access to high quality care.

We agree with the approach strongly advocated in many submissions: all nurses and midwives should help service users to improve their health, and all encounters, in whatever setting, should be used as opportunities for health promotion. They should seek to influence people's health-related attitudes and behaviour, and improve health literacy. The RCN, for example, told us, 'The 21st century nurse must have an understanding of public health and, regardless of their main place of work, promote health and equality [and] take the right action to prevent disease and identify it at the earliest possible opportunity.' UNISON said health outcomes for many people could be turned around with appropriate investment in public health practice.

Much illness, including major killers like heart disease and cancer, is preventable. The current policy focus on promoting health and keeping people out of hospital is reflected in many good examples of nursing and midwifery practice and education. Nurses and midwives are already playing a bigger part in tackling the leading individual risk factors for noncommunicable diseases – high blood pressure, tobacco, alcohol, high blood cholesterol, overweight, low fruit and vegetable intake, and physical inactivity (WHO 2006) – for example through the successful NHS Stop Smoking Services. They should build steps towards better health and wellbeing into the care plan of every service user.

Public health nursing

Nurses and midwives should be supported by a health system that focuses strongly on health promotion for all, while identifying and targeting those most in need, in the context of health and wellbeing policies from national and local government that tackle the wider social and environmental determinants. Promoting health, preventing illness and reducing health inequalities has long been central to some nursing and midwifery roles, and is the foundation of health visiting.

Nurses and midwives working in community settings have always been acutely aware of the factors that influence health. As several organizations told us, they are often in the forefront of developing services to meet the needs of disadvantaged groups such as homeless people, asylum seekers and vulnerable children, working in or alongside other agencies such as local authorities and third sector organizations, and leading joint working. For example, nurses in NHS Hull are tackling domestic violence as a public health issue.

Nurses should be involved in making policy that enables people to make healthier choices, we heard in NHS West Midlands, with calls for 'a greater emphasis on preventive health and health promotion within the health service.' Specialist community public health nurses should take the lead in developing and delivering health promotion and illness prevention strategies for service users, families and communities. They can raise awareness and build greater expertise in public health; assess community health needs; target specific interventions on those in greatest need; tackle health inequalities and the social determinants of health through individual and community interventions; create health-promoting environments; and ensure universal access to services. They should empower and train community members and carers to act as 'health change agents' and 'wellness coaches'.

There is growing evidence of the relationship between health and wellbeing in pregnancy and childhood, and health in later life, and also of the types of intervention by health visitors, school nurses, midwives, community nurses and others that maximize health and health potential (see example in Box 4.2.1). We were told that ensuring good health in the early years of life through programmes like Sure Start and the Healthy Child Programme was central to the future of the economy and sustainability of health services (Department of Health and Department for Children, Schools and Families 2009). Urgent measures are required to ensure appropriate capacity and authority to lead the programme now and in future.

Box 4.2.1: Reaching out to the community

Nurses, midwives and health visitors working in NHS Great Yarmouth and Waveney community services are using innovative ways to bring their public health interventions to the local population.

They were concerned at the high local rates of unplanned teenage pregnancy, and higher than national rates of chlamydia in the under-25s. Realizing that a more innovative approach was needed than the traditional family planning service, a nurse consultant and a sexual health lead nurse were appointed as part of an integrated Contraception and Sexual Health service.

An HPV team was set up to respond to the Government's accelerated programme of vaccination against the human papillomavirus to prevent cervical cancer. The team used many innovative approaches to reach out to its target group of girls and young women in school year groups 8-13. It promoted the vaccine in schools on 'pink days'; sent reminders to mobile phones; sent mail shots; and put up posters in hairdressers, tanning centres, nail bars, pubs, clubs, clothes shops and chemists.

Effective use was made of the local media through radio advertisements and interviews. Information was offered at open college days and sessions in every school, and to parents though information sessions and an advice line. A named nurse was allocated to each school and immunizations were offered at walk-in clinics, also open on Saturdays and in the evening, and through home visits if necessary. Uptake of the completed vaccination course rose in Great Yarmouth to 90% for 12-13-year-olds and 83% for 17-18-year-olds.

The breastfeeding team aims to raise breastfeeding rates, achieve accreditation to the UNICEF Baby Friendly initiative, and train all practitioners to UNICEF standards. Good practice includes helping women and men to socialize antenatally in a breastfeeding environment, which is known to increase the initiation of breastfeeding significantly.

The RCM said all midwives should be able to identify and understand the key health and social issues that affect women, such as domestic abuse, diabetes and obesity, and to signpost the relevant specialist services. School nurses, said Unite, should take overall responsibility for public health outcomes among schoolchildren. Parents and children at our engagement events told us how highly they valued school nurses, suggesting they could undertake a lot more preventive work: 'We should get nurses into schools to work on health promotion and raise the profile of nursing.'

We heard examples of good practice in public health nursing, but they were also described as patchy, poorly researched and disseminated, and low visibility. Effective solutions are often found in projects that are not sustained or mainstreamed. More needs to be done urgently to scale up the nursing and midwifery contribution to health and wellbeing. Public health leadership of both provider and commissioning functions needs strengthening in some areas, and aspects of care related to health and wellbeing should be fully recognized in the commissioning process and payment framework. Nursing and midwifery expertise needs to be heard and heeded in commissioning population-facing services, striking a better balance with the shorter-term imperatives of acute health care.

Concern for health and wellbeing today includes concern for the environment. Health services should meet the needs of today without compromising the ability of future generations to meet their own needs, including reducing waste, doing more with less, and cutting health-related carbon emissions. The NHS Sustainable Development Unit told us about the health sector's huge carbon footprint and enormous waste, and the urgent need to create climate-friendly hospitals and communities (NHS Sustainable Development Unit 2009b). Few other organizations raised these issues directly, but we believe they are of major importance. Nurses and midwives should introduce policies and practices to promote sustainability and minimize the impact of climate change on health and health care.

Workforce and capacity challenges

We heard much about the continuing need to tackle the workforce challenges facing primary health care nursing. These have been noted for some years, for example in the Wanless reports (2002, 2004). A disproportionate number of health visitors, school nurses and practice nurses are expected to retire by 2020 (NHS Workforce Review Team 2008). Areas proposed for improvement included giving frontline staff the right support, skills, and competencies to design and deliver public health services; protecting public health and prevention budgets; more research on the cost-effectiveness of nurse and midwife-led health promotion and disease prevention; and more education on health and wellbeing.

Many questions must be addressed urgently. They include the shape of the primary health care nursing workforce needed for the future; its balance of generalists and specialists, in the light of proliferating specialist and advanced roles; the role and responsibilities of GPs in nurses' training, support and supervision; the roles and professional/managerial relationships of practice nurses; and the health promotion and care management functions of different nursing roles.

Nurses' and midwives' health and wellbeing

'If you can't improve the health and wellbeing of nurses, how can you expect them to improve the wellbeing of patients?', we heard in NHS Yorkshire and the Humber. Promoting and protecting the health and wellbeing of staff is vitally important. Trade unions, other stakeholders and individual professionals raised longstanding concerns about the ongoing need to address employment issues like family-friendly working and other terms and conditions that have a major influence on staff and are the foundation of happy and productive workplaces. As UNISON suggested, poor care 'may not be just about the personality of nurses, and can reflect the context in which people work'. 'The health of nurses on the ground floor is directly related to and affected by the health and functionality of the organization and the health service as a whole,' we heard in NHS East Midlands.

Nursing and midwifery staff are part of the communities they serve, and subject to the same pressures. Respondents specifically mentioned evidence of poor mental and physical health, particularly related to smoking, obesity and alcohol abuse. While being exhorted to work more productively, they are affected by the economic downturn at home and at work. Many are becoming the primary family

earner, often on a modest income, or working longer hours to make ends meet while balancing the demands of caring for elderly relatives or children. They are concerned about the future: as one nurse told us, 'the constant worry about our future is casting a huge shadow over the workforce, and I feel it is beginning to eat away at the dedication and enthusiasm of staff.'

We think nursing and midwifery leaders should champion staff health and wellbeing. The Council for Healthcare Regulatory Excellence told us that nurses and midwives play important roles in educating and assisting patients in making choices that are right for them – and should therefore also be 'role models of healthy living'. The Queen's Nursing Institute said, 'We need to encourage nurses to care for themselves as much as they do for their patients… for their own sakes.'

Employers must do more to help health workers to heed their own health messages. These themes were well developed by Boorman's independent review of NHS health and wellbeing (Department of Health 2009d). Its final report made the business case for change, pointing out the link between staff satisfaction and service user satisfaction, and proposed comprehensive recommendations for improving staff health and wellbeing. 'Organisations that prioritised staff health and wellbeing performed better, with improved patient satisfaction, stronger quality scores, higher levels of staff retention and lower rates of sickness absence,' it said. We welcome the government's commitment to taking this work forward in the NHS and we urge all employers of nursing and midwifery staff to take similar steps, using tools such as the annual NHS staff survey to measure progress.

Recommendations

Nurses' and midwives' contribution to health and wellbeing

Nurses and midwives must recognize their important role in improving health and wellbeing and reducing inequalities, and engage actively in the design, monitoring and delivery of services to achieve this. Commissioners of services must create incentives to encourage nurses and midwives to turn every interaction with service users into a health improvement opportunity.

A named midwife for every woman

The contribution of midwifery to delivering health and wellbeing and reducing health inequalities must be enhanced by organizing services so that every woman has a named midwife responsible for ensuring coordination of her care and providing support and guidance.

Staff health and wellbeing

Nurses and midwives must acknowledge that they are seen as role models for healthy living, and take personal responsibility for their own health. The recommendations of the NHS Health and Wellbeing Review (Boorman report) must be implemented in full, so that employers value and support staff health and wellbeing and thereby enable them to support service users.

Chapter 4.3
Caring for people with long-term conditions

Caring for people with long-term conditions: our call to action

Nurses are centre stage to handle the huge and growing need for skilled care – the 'carequake' – arising from changes in demographics, health trends, the economic and social environment, and other drivers of supply and demand in health care. People with long-term mental and physical illnesses and disabilities and the complex needs of ageing require continuing skilled care to maximize health and wellbeing and have a dignified death. Their needs range from education for self-care and family support to preventing or slowing complications and deterioration, and managing exacerbations to prevent hospital admission. Nurses must be properly equipped and supported to take on new roles as lead professionals, care coordinators and specialist clinicians. The proportion of nurses able to work outside hospitals should rise much faster; pre-registration courses should have a strong focus on long-term conditions; and new large-scale bridging programmes should equip staff with the necessary competences and the ability to work flexibly across settings and organizational boundaries.

Long-term conditions are chronic mental or physical illnesses or disabilities such as diabetes, depression, learning disabilities, and the multiple, complex health needs associated with ageing. Over 15 million people live with a long-term condition in England, and numbers are expected to rise due to an ageing population, unhealthy lifestyle choices, and increased survival from serious illness, trauma and congenital problems due to advances in care and treatment.

The future work of many health professionals, especially nurses, will increasingly focus on these conditions. Maintaining wellbeing and independence, promoting health and preventing further deterioration or further health problems will all form part of meeting these complex needs. Dealing with the huge and growing need for skilled care in the coming decade and beyond – the carequake – will require much stronger nursing involvement in preventing and managing long-term conditions and the end of life through community-based continuing care, a consensus view we heard during our engagement exercise.

Most people with long-term conditions or approaching the end of life do not want to consider themselves as 'patients'. We spoke to many who wanted service users to be able to manage their own care, especially those with long-term conditions, and said nurses and midwives should be educators and advocates as well as care-givers. 'Nurses' role is moving towards enabling, standing back and listening to what intervention is wanted by the person,' we heard in NHS South West. 'With long-term conditions there is a lot to do with facilitating the patient to educate themselves,' we were told in NHS London.

In future, all service users should have integrated care whichever individual, organization or sector provides it, enabling them to be treated and cared for mainly in community settings, funded as they choose from their personal health budget. As a service user told us, 'the acute and community setting should be integrated, so that more nurses can outreach from hospitals into the community to support patients who require ongoing or long-term nursing care support at home.' Another service user at our Manchester event said continuity was important – 'map out a process of care and keep you informed.' *High Quality Care for All* (Department of Health 2008) envisages personal care plans for everyone with a long-term condition, agreed by the service user and a named professional, who is increasingly likely to be a nurse.

Some clinical management will take place in acute hospitals, such as hip replacements, removal of cataracts and cardiac bypass, but most will be community-based rehabilitation and clinical surveillance, making full use of remote care and other technological improvements. Many of these people will have multiple pathology. Giving them high quality care will require multidisciplinary teamwork – no single profession will have all the expertise. Most care at home will continue to be provided by England's six million lay carers, so nursing staff and other health and social care workers must work in partnership with them.

The quality of care of people with long-term conditions and approaching the end of life is already being revolutionized by better care management, with community matrons and other community nurses coordinating the inputs of doctors, specialist nurses, therapists and others throughout the care pathway, using remote care technology, and working in multi-agency teams. Increasingly they will work not in traditional organizational or career structures, but in flexible new roles designed to deliver services where people live and work, in partnership with citizens, carers and other professionals, and across sectors and agencies.

Care pathways for people with long-term conditions and at the end of life should be developed jointly by service users and professionals, using the best available evidence to define expected standards of treatment and care. Future nurses and midwives should 'treat patients as individuals and partners in their own care,' a service user told us. Commissioning frameworks will be designed to promote independence and self-help and to avoid hospital admission as much as possible. They will recognize the full potential of the nursing contribution, including the ability to prescribe and to take or make direct referrals.

Generalist community nurses can play a vital role in coordinating services, maximizing continuity of care during the entire care pathway, advising on individual service users' needs, and encouraging self-management by helping service users negotiate their way through the sometimes bewildering variety of services and support agencies available. People wanted community nurses to work more closely with community matrons and practice nurses on chronic disease management, we were told in Manchester.

Community services that allow direct referral to primary care nurse practitioners enable them to 'mobilize services in hours rather than days' and avoid hospital admission, according to a review we commissioned on meeting the needs of people with complex conditions (Ross et al. 2009). This study also highlighted the community matron as key to maintaining people with complex and multiple long-term conditions in the community. These posts ensured effective communication between primary and secondary care, and successful integrated working, such as night services funded jointly by health and social services.

Effective specialist roles must grow, based in community settings and able to accept direct referrals from service users, carers and other health workers. Plans announced in 2010 envisage one-to-one care from specialist cancer nurses in service users' homes. Other good examples include specialist nurses for people with Parkinson's disease or drug addiction, and teams of community children's nurses supporting children with complex multiple conditions to live and sometimes die at home. Their work includes leading and training teams of carers and support workers, coordinating care packages, liaising with local and specialist services and providing emotional and practical support. Clinicians working with children told us that the expansion of these services would reduce hospital admissions, facilitate effective timely discharge and provide better access to nursing care at home for children with long-term conditions.

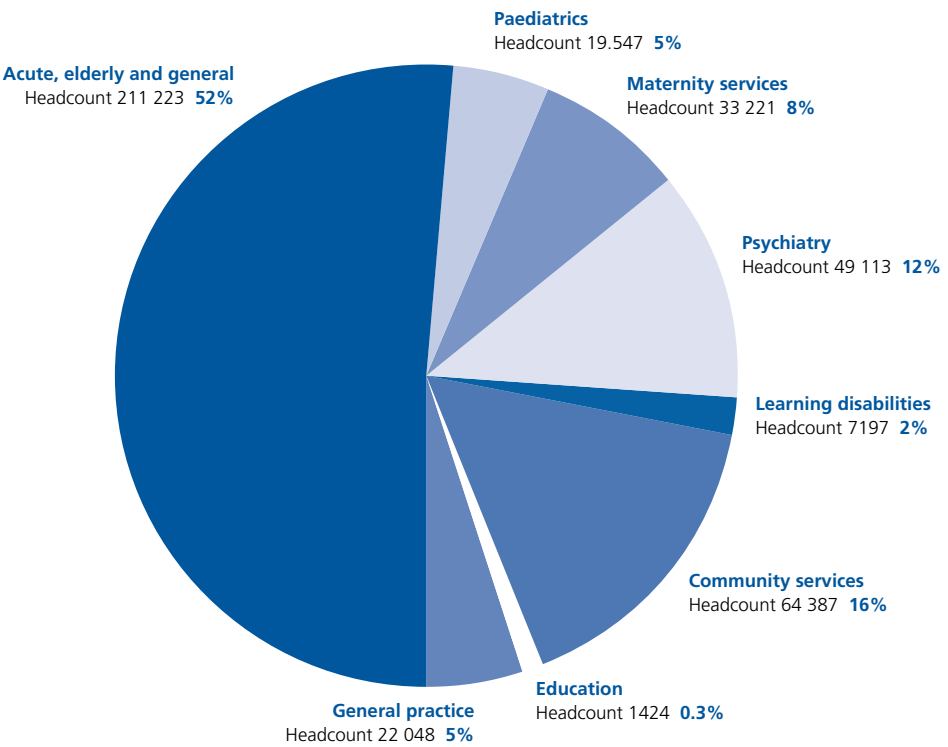
Workforce challenges

Major shifts are required both in flexibility of roles and in the settings where staff are based if the vision is to be achieved. At present, as Table 4.3.1 indicates, the majority of nursing and midwifery staff in the NHS work in acute hospitals. Those working in NHS community settings comprise perhaps a third of the NHS nursing and midwifery workforce in England. They include nurses in community services (16%), practice nurses (5%), learning disabilities nurses (2%), and the majority of the 12% of nurses who work in mental health. In addition, most nurses employed outside the NHS work in non-acute settings such as nursing homes.

Community nursing faces other workforce challenges. Nurses in NHS community services have a markedly older age profile than other RNs (Buchan and Seccombe 2009), and a disproportionate number of district nurses and practice nurses are expected to retire by 2020 (NHS Workforce Review Team 2008). The impact of retirements will hit the community sector earlier and harder, and could exacerbate local staff shortages.

Other interacting factors include a sense of decline and low morale in some places, reported by the Queen's Nursing Institute and others. Areas proposed for improvement included giving front-line staff the right support, skills and competencies to design and deliver services; improving the educational infrastructure; and increasing training and development budgets.

Table 4.3.1: The NHS nursing and midwifery workforce in England by area of work (NHS Information Centre 2009)



Many people with long-term conditions require help from a range of services and agencies. They often see many different staff, which can create confusion, fragmentation and duplication of effort. Holding their own health and social care budget will give service users many more options about how, when and from whom they receive support. These changes challenge traditional notions of what type of care can be delivered and by whom. They also require dissolution of the barriers between services, settings, agencies and professions. Such barriers are rare in maternity services, which provide an example of how care can be organized around the service user and not the professional. Nurses should be in the forefront of driving and delivering this radical shift – which requires them to scrutinize current practice and develop innovative and flexible roles, ways of working and forms of organization.

Organizational structures that place nurses in a central, coordinating role must be supported by single, efficient and generic recording systems, compatible with both health and social services and with common, compatible IT software. Commissioning frameworks must also take account of the potential of the nursing contribution, making full use of the legal and professional flexibilities that already exist (such as independent prescribing and implementing Responsible Clinicians under the Mental Health Act 2007). Such pathways will enable direct referrals by nurses to others including doctors, allied health professionals and social care colleagues. Aspects of care related to maintaining independence should be fully recognized in the commissioning process and payment framework.

Some of these changes will call for revisiting the division of labour to create new roles and accountabilities, such as substituting a professional with someone more junior or from a different occupation, or delegating tasks to less qualified personnel. Practitioners who work across organizational and professional boundaries need to be bold, and staff should manage the change well through good communication and engagement.

For example, a child health nurse caring for a child with a chronic illness would in future range across health, social care and education settings. The practitioner might undertake nursing and physiotherapy, and sometimes a medical role such as deciding whether to admit the child to hospital. She or he would care for the child in hospital, at home and at school, administering complex medications such as intravenous drugs when necessary in all these settings. She would provide nursing care when required during an acute exacerbation, or regular physiotherapy when family members are unable, and protect the social welfare of the child and family. Very close partnership with the child's family and carers will be essential, teaching them practical skills and sharing health knowledge.

The professions need to be adaptive, proactive, flexible and responsive to change. This means not being tied to traditional career progression points, but creating opportunities for lateral movement to gain experience with different care groups in different settings. We need to build on existing career structures while also thinking creatively. This may require tapping into funding streams designated for the redevelopment and redeployment of staff into new roles, especially in primary health care, and updating the education workforce alongside the development of flexible career structures. Asking nurses to move from working in hospitals to community settings will require extensive training programmes to enable them to acquire the necessary competence and confidence.

We were interested to learn of innovative educational approaches such as a foundation degree for long-term conditions that aims to prepare assistant practitioners for a range of settings in health and social care, bringing together skills of nursing, therapy and social care (Hasselder et al. 2009). The teaching team mixes staff from physiotherapy, nursing and social work. The contribution of assistant practitioners and other support workers will be vital to help meet the demands of the carequake.

Recommendations

Nursing people with long-term conditions

The redesign and transformation of health and social care services must recognize nurses' leading role in caring for people with long-term conditions. Care pathways must be commissioned for service users that maximize the nursing contribution. Nurses must be enabled to make direct referrals to other professionals and agencies, and all barriers that prevent them from utilizing their full range of capacities and competencies must be removed.

Flexible roles and career structures

Commissioners and providers of education must ensure that nurses are competent to work across the full range of health and social care settings. Flexible career structures must be developed to enable them to move across settings within existing roles and when they change jobs.

Chapter 4.4
Promoting innovation in nursing and midwifery

Promoting innovation: our call to action

Nurses and midwives are already working in new ways and sometimes in new roles in response to service users' needs. Radical shifts in service delivery and philosophy, including the entrepreneurial spirit of social enterprise, provide important opportunities to increase their impact. More support is needed to help nurses and midwives encourage and embed innovation, including workplace cultures that stimulate new ideas and enable them to champion and deliver high quality, compassionate care in innovative ways. Transformational teams should be established, led by nursing and midwifery innovation fellows, to raise standards and introduce innovation through peer review.

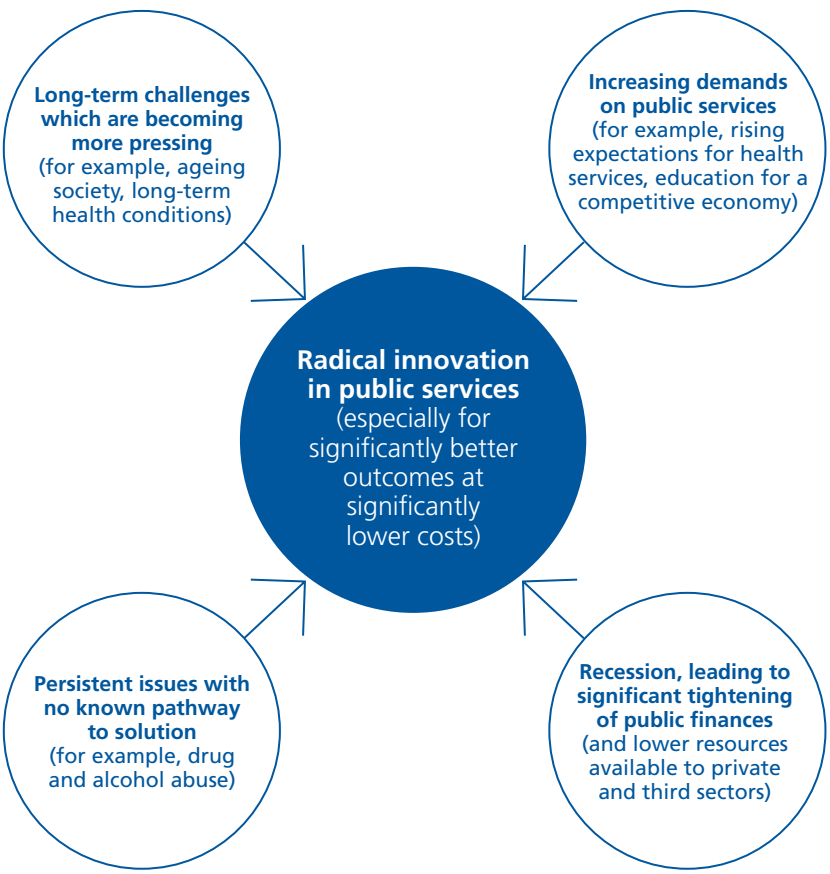
Our goal is that innovation will become a way of life in public services. Nurses and midwives at all levels will be encouraged to think innovatively, and to come up with new solutions that influence system design as well as service delivery. Every health organization will provide the right leadership and culture to support innovation and create a positive practice environment that brings benefits to service users and practitioners. Leaders will understand and strengthen the links between high quality care, cost-effectiveness and staff development. The team will be the crucible for innovation, and local empowerment will create local solutions. Lessons will be learned from successes and failures, and best practice will be spread strategically into the mainstream.

High Quality Care for All (Department of Health 2008) highlighted the need to encourage a culture of innovation and speed up the mainstreaming of good ideas. Nurses and midwives should play a central role in this, and some already are: we were given many examples of good practice and models on which to build. Innovations in practice and service delivery have always been a feature of nursing and midwifery. Although the pace and extent of such innovation has accelerated, however, it has often been difficult to sustain – and slow and fragmented uptake of innovation is no longer sufficient in the changed context of public services today.

Innovation experts describe a 'perfect storm' of forces similar to those we outlined earlier – pressing long-term challenges, increasing demand on public services, persistent difficult issues, and tighter public finances – that create an 'innovation imperative' (Figure 4.4.1) (Harris and Albury 2009). Radical innovation in public services, especially for significantly better outcomes at significantly lower costs, is seen as the only sustainable response. We endorse their core messages (Albury 2009):

- Efficiency and cuts are insufficient to tackle the challenges, demands and pressures on public services; fundamental innovation is necessary.
- Creating the conditions for radical public service innovation requires more than great leadership.
- Successful and effective innovation emerges from disciplined and systematic approaches, not just 'letting a hundred flowers bloom'.

Figure 4.4.1: The innovation imperative



In Part 3 we cited evidence that innovative services and interventions led by nurses and midwives can deliver higher service user satisfaction, improvement of some outcomes (particularly in relation to concordance with treatment), positive changes in lifestyle and improved use of appropriate services (Caird et al. 2010). Some are specific and focused, such as nurse-led discharges from secondary care, and a groundbreaking bereavement and donor support service (Box 4.4.1).

Box 4.4.1: Nursing innovation 'led by an invisible hand'

Death is the only thing in life of which we are certain, and there is little excuse for being less than fully prepared, says the nurse-led Bereavement and Donor Support Team at Royal Bolton Hospital NHS Foundation Trust. It aims to ensure universal access to bereavement care of the highest quality to the relatives and carers of people who die in hospital.

This innovative, award-winning service is centred on the patient and family and empowers and enables staff to offer them choices and control in an often uncontrolled situation. It embraces the concept of organ and tissue donation as a usual rather than unusual part of end-of-life care, and has challenged resistance to linking these two historically separate areas. It offers families the opportunity to help with last offices and care for their loved one after death.

Before the team was established in 2004, bereavement care was fragmented throughout the trust, as it is throughout the NHS. Quality and choice depended on where in the hospital a person died and who was on duty at that time. Organ and tissue donation rates were low as it was not considered part of end-of-life care. The team began to join together the hitherto unconnected pieces of a jigsaw of policies, guidance and legal documentation on death, dying and donation, and to develop local policies involving multi-agency partners such as pathologists, anaesthetists and the coroner. Working with the public and service users, it developed education materials and resources for the wider health economy.

The driving force is team leader Fiona Murphy, thought to be the only nurse in England appointed clinical lead for donation. 'The most ambitious challenge has been to change the culture of the organization to enable donation to be accepted as a normal part of end-of-life care,' she says. The barriers have been overcome by persistent advocacy, close interprofessional collaboration, intensive training for staff from nurses to porters, and support from all tiers of management – together helping to change the culture. A similar service based on the Bolton model is developing at Lancashire Teaching Hospitals NHS Foundation Trust.

The most important outcomes, Fiona says, are the many patients treated with the utmost care and dignity during and after their death; relatives supported in their grief; relatives offered the choice of donation and given the opportunity to say No; and numerous people receiving organ and tissue donations. 'Many staff have been led by an invisible hand and empowered to give the care that should be offered to everyone irrespective of where they die,' she says.

Other innovations support nurses to provide more of the everyday care service users need, such as nurses prescribing medicines, a development that faced enormous resistance and progressed very slowly, but was recently evaluated as sound and effective (Courtenay 2008). There are opportunities for further developing midwifery-led models of care through addressing the issues of professional culture and relationships. The best maternity units have a strong culture of mutual respect and recognition of professional interdependence.

We heard how the community base of third sector organizations could help mainstream health and nursing services to provide better, more innovative care. The strategic health manager of the Goodwin Development Trust in Hull, herself a nurse, told us that consultation and the collection of evidence to identify gaps in service provision could put the needs of consumers and client communities at the centre of reform (Bell 2009). 'They could help them design innovative and creative services that echoed the voice of the community; work with statutory and non-statutory providers of health and social care in coalitions and partnerships to support professionals in promoting health and wellbeing; and develop new roles in learning, volunteering, and employment to support professionals' preventive and early intervention roles,' she says.

More joint working of all kinds is vital for innovation. Positive practice environments can be created through innovations in design and technology that build on input from service users and clinicians, and are developed in partnership with technical and industrial experts. Nurses have played a leading role in design work aimed at practical and cost-effective measures to reduce healthcare-associated infections and maintain service users' dignity, for example in a collaboration between the Design Council and the Department of Health, England (box 4.4.2). 'Innovation is the genius that lies within,' said David Kester, chief executive of the Design Council. 'If you empower nurses they are ready and eager to provide the insights and ideas that feed continuous innovation.'

Creating a culture of innovation

Innovation requires entrepreneurial leadership, but the systems in which nurses and midwives work, and the behaviours they learn, tend to foster passivity and risk aversion rather than creativity. Research on nurses' role in adopting and assimilating technological innovations into routine clinical care suggests that the processes utilized by NHS organizations for adopting new technologies are still unclear and poorly understood (National Nursing Research Unit 2009). 'Furthermore, it is not clear whether nursing leaders have a voice with regards to the implementation of innovative methods,' it said.

Many nurses and midwives spoke passionately about the obstacles in their way. Despite lip service to change, their lived experience was inertia and resistance. Some barriers were systemic; others lay in colleagues' attitudes; and yet others lay within nurses and midwives themselves, especially low self-esteem.

Box 4.4.2: Designing a world-beating commode

Practical improvements in equipment and the care environment were developed through collaboration between the Design Council and the Department of Health. Two projects – Design Bugs Out and Design for Patient Dignity – challenged the UK's top product manufacturers to work intensively with nurses, who identified priority areas for design teams, developed designs, and provided feedback from users.

The results include a set of products designed for easy and effective cleaning to minimize the risk of infection, such as commodes, chairs and blood pressure cuffs. Nurses also worked on ideas to improve privacy and dignity, including redesigning patient gowns, more dignified toilet and washing arrangements, and rethinking ward layouts to allow greater privacy and separate mixed-sex accommodation.

Nursing input was vital to the success of the projects. 'Using feedback from patients and nurses, rather than just relying on technical and ergonomic guidelines, the teams produced a robust, functional and easy-to-clean commode which minimizes the risk of infection without compromising patient dignity,' says Mel Taylor of the Design Council. 'The result has been celebrated by the Design Museum as an exemplar of ergonomics and has provided UK designers and manufacturers with a world-beating product with orders internationally.'

Susan Osborne, former interim chief nurse of NHS East of England and a member of the judging panel, says nurses' involvement offers a blueprint for the future. 'This approach of bringing manufacturers together with designers, advised by health professionals, should be adopted as the normal way of commissioning products for the health service,' she says.

We were told about the paramount importance of workplace culture and organizations demonstrating that they value and reward change agents. 'Delving into new domains does carry risk,' we heard at our event in NHS North West. 'You need very supportive structures to set it up, and a supportive infrastructure. It depends too much on individuals.'

The expectation that midwives always adhere rigidly to standards could seriously inhibit innovation, the RCM told us; how risk is managed and how standards are used can be an incentive or a deterrent. The relationship with and attitudes of colleagues could also be a hindrance. 'Trying to lead services in multidisciplinary teams is difficult. Sometimes nurses don't have the authority to overcome barriers,' we heard at our event in NHS North West. A charge nurse told us how the medical consultant on his unit refused to allow him to prescribe, even though he had gained the necessary qualification. Nurses spoke of GPs refusing to allow them to refer patients, and hospital consultants refusing to discuss patient care or receive referrals. 'Tissue viability is a nurse-led service, so we're considered the experts – yet to make vascular or dermatology referrals we have to go via the GP to refer them, rather than doing it directly,' we heard in NHS North East.

Our visits to healthy living centres and social enterprises highlighted excellent innovative achievements that had to overcome strong disincentives to nursing and midwifery entrepreneurs seeking to lead and run services and develop new models. These included bureaucratic obstacles, limited access to information, lack of transferability of NHS pensions and indemnity insurance issues.

We often heard that nursing and midwifery leaders needed more confidence to grasp change opportunities. Some middle managers lacked the support, willingness, breadth of vision or entrepreneurial flair to take the initiative, and were overly focused on the short term. Nurses and midwives should help change these individual and system barriers by using peer review to drive improvements. 'Sometimes you do not know it is best practice because you have always done it like that,' we were told by nurses in NHS South Central. 'Peer review is a good because you can help make sure people recognise best practice and it is disseminated.'

Innovation and improvement cannot be sustained by sporadic short-term initiatives. Transformational leadership, peer support and employee engagement should become a way of life to create a culture of innovation, rather than the top-down management style that often typifies everyday life in health services. Policies, continuing professional development and other incentives must be aligned to support this. We support current initiatives to boost innovation, and call on NHS SHAs and health innovation and education clusters to do more to facilitate the contribution of nursing and midwifery. They should rebalance their predominantly medical focus, and scale up nursing and midwifery involvement and funding commitments in all their activities.

'In my area we have a transformation team; they give us the tools and encouragement to sustain change. It helps you articulate your plan in a structured way,' we heard in NHS West Midlands. Building on this existing good practice, we propose a new scheme to encourage innovation in service delivery. Innovation fellows should be appointed to lead transformational teams that will visit wards, community teams, and health, social care and community organizations to review with them how to tackle poor care, raise standards and embed innovation and excellence.

Making best use of technology

Making best use of technological advances is an increasingly important aspect of high quality care, including innovative 'remote care' approaches such as telenursing, as well as improving metrics. The success of NHS Direct demonstrates what can be achieved in nurse-led services. Starting in their initial education, nurses and midwives need a better understanding of and influence over the development of new technologies and informatics, including information and communications technology and remote care. This should be accompanied by urgent investment in the development and supply of information systems to front-line staff.

The use of standardized terminologies is an essential precursor to nurses and midwives' effective use of information technology. Education on the use of such languages is included in pre-registration education, but needs to be embedded in all practice domains if the data that nurses and midwives collect are to have value.

Progress on these longstanding concerns should be accelerated through a collaborative approach involving employers, regulators, practitioners and educationalists, to determine how to build nursing and midwifery capacity to understand and influence the development and use of new technologies.

Recommendations

Building capacity for innovation

Fellows should be appointed to promote nursing and midwifery innovation in service design and delivery, as champions of change and leaders of transformation teams that raise standards and embed innovation and excellence through peer review and support. Development of the entrepreneurial skills that nurses and midwives need to lead and respond to changing demands and innovative models of care must be included in pre- and post-registration education and training.

Making best use of technology

A high-level group must be established to determine how to build nursing and midwifery capacity to understand and influence the development and use of new technologies. It must consider how pre- and post-registration education and development programmes could best deliver technological understanding and skills for information, communications and practice.

Chapter 4.5
Nurses and midwives leading services

Nurses and midwives leading services: our call to action

Putting nurses and midwives in the forefront of leading and managing services brings many benefits. They need more development and support to be effective leaders, as well as clearly defined and appropriate accountabilities and roles. Employers, managers and professional colleagues should be fully committed to involving nurses and midwives in making policies and decisions, from the board to the point of care. Leadership from the ward sister and equivalent linchpin roles in midwifery and community settings should be strengthened. Innovative organizational models such as social enterprises led by nurses and midwives also provide important opportunities for improvement and innovation, and should be supported and extended where locally appropriate. These changes should be driven by health policy and guidance, and enabled by appropriate management structures and supportive workplace cultures. Comprehensive development and mentorship programmes must be scaled up to identify and fast-track talented potential leaders.

We heard from the public, service users, nurses and midwives and some professional colleagues that they want greater recognition and valuing of nursing and midwifery leaders, especially those in visible roles such as the ward sister that should be the linchpin of clinical leadership. 'I don't think they get the respect for the skills set and the knowledge that they have and it's down to awareness of it,' we were told in Manchester.

Creating the right climate for wise leadership will encourage best practice and bring benefits to service users and practitioners. Every health organization and team should create a culture that enables nurses and midwives to be fully involved in the leadership, design and development of services, and to lead their own services where appropriate. In turn, nurses and midwives should be more assertive and confident to grasp leadership opportunities, and ensure they have a powerful voice from policy-making to the point of care. Those already in leadership positions will support and encourage existing staff and inspire and nurture the next generation. Leaders will be appropriately prepared for their roles and equipped with clearly defined skills and competencies. Effective nursing and midwifery leadership should be exercised at all levels, and structural and attitudinal barriers minimized.

Services led by nurses and midwives

Nurses and midwives already develop and manage their own services within and outside the NHS. These include clinics and care pathways led by nurse and midwife consultants, and midwifery-led birth centres. Many nurses own and run care homes for elderly people. A growing minority are setting up innovative forms of organization such as social enterprises, and tendering for services in community health, general

practice, midwifery, occupational health and case management. The shift to delivering care closer to home and focusing on caring for people with long-term conditions provides new opportunities for nurse-led and midwife-led services.

Improving access to urgent primary care, including out of hours, is one example of nurses leading services in response to changing needs. We visited the nurse-led Clover Centre in Swindon, which aims to ensure that service users have rapid assessment and access to the right level and place of care, reducing unnecessary admissions and improving quality and safety. It acts as a single point of access for a huge range of community and specialist services. These include telephone triage and acute assessment of GP referrals, coordination of care pathways such as end-of-life care utilizing telehealth technology, and a walk-in centre run by nurse practitioners.

More direct access to nurse-led and midwife-led services would improve cost-effectiveness and health outcomes, and remove system blockages that delay appropriate care, as we saw in Part 4 Chapter 3. 'The ageing care team is great. Patients ring the team rather than call A&E and are assessed by an experienced and qualified nurse – there should be more of these,' we heard in NHS North East.

Robust evidence of the benefits of nurse-led services emerged from the systematic socioeconomic review we commissioned (Caird et al. 2010). These included improved outcomes in nurse-led inpatient units, such as functional status, psychological wellbeing and lower readmission rates, and fewer visits to accident and emergency departments for people with respiratory conditions. An award-winning, nurse-led paediatric urgent care social enterprise in London enabled service users who would formerly have been admitted via A&E to have their care managed at home with support.

We also heard evidence of effective midwifery-led care and leadership. Our systematic review concluded that midwife-led care for low-risk women improved a range of outcomes, reduced the number of procedures and improved satisfaction (Caird et al. 2010). The proven safety of midwife-led care means there are distinct opportunities for more midwife-led services to be developed and supported across the NHS, especially in non-traditional locations that give easier access to key support such as social services, health visiting and the third sector, the RCM told us.

The social enterprise philosophy is ripe for nursing and midwifery leadership. Social enterprises are businesses with primarily social objectives whose surpluses are reinvested for that purpose in the business or the community. They stimulate engagement and empowerment of staff and service users to devise new, effective ways of delivering services, as we saw in two organizations we visited – Central Surrey Health, the first employee-owned social enterprise in the NHS (Box 4.5.1), and the third sector Goodwin Development Trust in Hull. Both have strong nurses in leadership roles and link well with other nursing and midwifery leaders. We note the growing evidence base that demonstrates the many benefits of employee engagement, which in turn facilitates transformational nursing and midwifery leadership (Ellins and Ham 2009). The lessons apply to all organizations, not only those formally labelled as social enterprises.

Box 4.5.1: Entrepreneurial nursing leadership

Central Surrey Health is an award-winning co-owned business that provides community nursing and therapy services to a population of 280 000. It combines the people-centred values and principles of the NHS with the drive of a successful business. Joint managing directors Jo Pritchard, health visitor and nurse, and Tricia McGregor, speech and language therapist, have a clear vision for the organization: 'We will be the provider of choice, recognized for the excellent provision of integrated healthcare services. Central Surrey Health co-owners will lead the field in developing outstanding and accessible services.'

Its mission is to 'revolutionize healthcare in our community by bringing new solutions to old problems and working tirelessly to improve health standards for all.' To achieve this it stands by three core principles. First, it operates as a social enterprise. Second, it is co-owned by its employees. All its nurses and therapists own a 1p share in the business and have a real and equal say in how it is run. This is motivating and engaging, and has helped create an open, honest, can-do culture. Third, clinical leadership is at its heart. Its senior management and clinical team are all nurses or therapists, so people in touch with service users' needs are in charge of providing and developing services.

It began in 2006 with a focus on streamlining and coordinating clinical services to improve service users' experiences. As a result, it changed its structures to integrate nursing and therapy services where appropriate and make them more patient-focused. This enabled the development and delivery of more integrated pathways of care. Other innovations include an organization-wide programme to improve quality, efficiency and effectiveness.

Barriers to change

Despite these successes, the proportion of nurses and midwives working in entrepreneurial roles is relatively small, especially for larger-scale developments such as leading new provider organizations or becoming full partners in general practice. We heard a range of explanations as to why more of these opportunities are not being taken up, and how the development of nurse-led and midwife-led services could be accelerated.

A major barrier to change concerns public uncertainty or ignorance about the qualifications and competence of nursing and midwifery leaders. 'We have to let the public know what nurses are capable of and that they will be taking the lead in services. Our walk-in centre does not have any doctors, which can be a surprise to patients – but it is gradually becoming more and more acceptable; it will filter through that nurses can and will do more and more,' we heard at our event in NHS North West.

Most service users who had actually experienced nurse or midwife-led services and interventions were enthusiastic: 'They lead everything anyway! I see them for everything,' a service user told us. 'I was three months in a stroke centre. I didn't realize nurses had the rehabilitation skills before – I didn't see a doctor the whole time. I really got quality of care with the nurses', said a service user at our Manchester event. Perhaps tellingly, it was those who had not experienced nurse-led services and interventions who feared that nurses did not have the necessary competence; that they would be exploited to deliver care on the cheap and not have time to do their 'real' job; and that the developments would cause tension with doctors. Although a third of service users' first NHS encounters are with nurses (NHS Information Centre 2009), and around 80% of women have direct access to midwives, most members of the public still saw doctors as the gatekeepers to the NHS.

We support the vision of clinical leadership advocated in *High Quality Care for All* and its inclusive definition of 'clinicians' as all staff who provide clinical care, including nursing and midwifery staff (Department of Health 2008). Not all organizations or senior colleagues share this inclusive vision, and this needs to change.

Many respondents told us that employers do not always make full use of nursing and midwifery expertise. Some attributed this to the lack of recent clinical experience among some nursing and midwifery leaders. This, they said, could result in a lack of clinical credibility and awareness and hinder them from taking a lead role in clinical governance. Many traditionally leave their clinical responsibilities behind on attaining senior and middle management roles. We urge every director of nursing and midwifery to maintain clinical awareness, through regular practice or other means.

Another barrier to effective nursing and midwifery leadership, we heard from the RCN and other stakeholders, is the loss of senior leadership roles, particularly in new community organizations and the commissioning arms of primary care trusts. The RCM was concerned at the low level of many senior midwives within the organizational structure. They often find it difficult to get the ear of the board or even of the senior nurses to whom they report.

Strengthening leadership capacity

Building capacity for leadership was a constant theme, with a particular emphasis on the need to acquire transformational leadership, business, commissioning and political skills. Such learning needs to start at the very beginning of nursing and midwifery education. In NHS North East we were told that nurses and midwives sometimes found it hard to access support and resources for developing their leadership skills: 'The organization needs systems in place to nurture and maximize the role of leaders. This has to be embedded in the culture.' Many stakeholders, including the RCN and the National Childbirth Trust, advocated more shared interprofessional learning to create a foundation of common competencies and improve teamwork.

There was much comment on the style of leadership needed for the future. 'It's to do with whether we're transactional (you will do this, that or the other – talking down to staff) or transformational leaders (embracing staff and recognizing skills and contributions)', we heard in NHS East Midlands. This was linked with 'working as teams, not in silos, being integrated and with mutual respect, with those in the team having clear roles and responsibilities and with a leader.'

Proof of leadership competence should be a prerequisite for leadership roles. Leaders take time to develop, and a full range of learning opportunities should be available including mentoring, secondments, networks and formal courses. Particular attention should be paid to family-friendly policies, funding and other means of ensuring equality of access to these opportunities, especially for black and minority ethnic staff and women, who are underrepresented in leadership positions. Those already in formal leadership positions should be strong role models – competent to lead changes, think creatively, support staff in their daily roles, and develop the next generation of leaders. 'It's about proper succession planning,' we heard in NHS South East.

There are already many excellent leadership programmes, within nursing and midwifery and more widely. Nursing and midwifery access to them needs to be scaled up, ensuring they are on a level playing field to obtain places on such schemes as the multiprofessional National Leadership Council initiative to develop leadership fellowships. The value of leadership development programmes needs to be enhanced by ensuring that participants have opportunities to practise what they learn and that suitable leadership posts are available.

We heard the plea many times from service users and staff that nursing and midwifery leaders should be more visible and communicative at the point of care. In our own engagement process as well as in other contexts, older members of the public and older nurses often described deriving a sense of authority, safety and confidence from well-known leaders like Matron and Sister that they now feel has vanished. Although the frequently authoritarian style of past leadership is not always suited to modern health care or effective teamwork, the call for stronger, more visible leadership must not be ignored.

Above all, respondents highlighted the erosion in many places of the role of the ward sister, charge nurse and equivalent team leader in midwifery and community settings. What we heard echoed the findings of an important recent study highlighting the importance of the ward sister role in taking forward the NHS quality agenda (RCN 2009c). These linchpin roles encompass generalist and specialist clinical supervision and practice, team leadership, management, education and much more. Accountable round the clock for the quality of care in practice environments, they provide professional and managerial leadership and support to nursing and other staff, sometimes to teams of 30 or more.

Although decisive in creating cultures that assure safety, improve quality and spread innovation, the status and authority of these roles has declined in recent years and some settings no longer have them. There are several root causes that include increasing prestige and better rewards for specialist practice roles; lack of attention to the 'advanced generalist' practitioner (analogous in some respects to the GP); erosion of nursing and midwifery authority over functions such as cleaning and catering; workload pressures that require them to deliver essential as well as complex care; and lack of development and support.

We support urgent calls from the nursing, midwifery and medical royal colleges, service users and other stakeholders to strengthen the role of the ward sister, and urge that joint work on this by the RCN, Department of Health, NHS SHAs and other stakeholders be accelerated. We also welcome valuable local initiatives as examples from which all can learn. These roles should be restored through re-established and enhanced posts, properly graded and rewarded, and continued development and investment in education and training. Their responsibility and accountability for budgets and health outcomes should be explicit. Post-holders and those aspiring to these roles should be better prepared and supported to acquire managerial and leadership competencies as well as being expert clinicians and supervisors of practice.

Recommendations

Strengthening the role of the ward sister

Immediate steps must be taken to strengthen the linchpin role of the ward sister, charge nurse and equivalent team leader in the midwifery and community settings. These clinical lead roles must have clearly defined authority and lines of accountability, and be appropriately graded. They must drive quality and safety, and provide active and visible clinical leadership and reassurance for service users and staff in all care settings. Organizational hierarchies must be designed to ensure there are no more than two levels between these roles and the director of nursing. Heads of midwifery should report to the board directly or via the director of nursing.

Fast-track leadership development

Regional schemes must be established to develop potential nursing and midwifery leaders, building on existing national work and learning from similar successful schemes in other sectors. They will identify talent, offer training and mentorship, and ensure that successful candidates who reflect the diversity of the workforce are fast-tracked to roles with significant impact on care delivery.

Chapter 4.6
Careers in nursing and midwifery

Careers in nursing and midwifery: our call to action

High quality care can only be delivered by a nursing and midwifery workforce that attracts and retains high quality recruits, is educated to be competent and compassionate, and undergoes continuing professional development and periodic revalidation of registration. A career in nursing or midwifery based on degree-level entry offers an exciting chance to make a real difference to the health and wellbeing of people and communities, and facilitates social mobility. Top quality recruitment, selection, education, support and professional development are fundamental to attracting, developing and retaining the best. New stories of nursing and midwifery are needed to create a fresh public image; raise general awareness of nursing and midwifery expertise; and highlight the many stimulating career opportunities as practitioners in every type of setting ranging from people's homes to oil rigs, and as managers, teachers, researchers, scholars and policy-makers.

Educating to care

Good initial recruitment, education and continuing professional development are essential to developing and maintaining workforce capacity. We heard much debate, particularly on recruitment to training; improving education; reducing attrition; and managing the transition to degree-level registration of all new nurses in England.

A recent review of the standards of pre-registration nurse education concluded that new programmes of nurse education should better reflect changes in health care delivery and equip newly qualified nurses to work competently and flexibly across health care settings. The NMC subsequently decided that degree-level registration was required to make new nurses fit for purpose, raising the level from the current minimum of diploma. In 2009 the government said all nurse pre-registration education programmes would become degree-level by September 2013. Midwifery and allied professions such as physiotherapy have already made this welcome shift.

Intense media coverage of this issue provoked much debate during our engagement phase. There was very low awareness that all nursing students in England are already educated at university to diploma or degree level, or that an estimated 30% of nurses currently hold a qualification at degree level or above (Ball and Pike 2009). Few service users or members of the public knew that degree-level registration had been successfully introduced for nurses in Northern Ireland, Scotland and Wales, and for some nurses and some allied health professionals in England. Few knew that all midwifery students are now educated to degree level in the UK, and they expressed no concern when so informed.

We were told nurses were no longer interested in providing care but wanted to be mini-doctors or managers carrying clipboards, linked to an erroneous view that all nursing education took place in classrooms. Some of these opinions were related to perceptions that nursing was an extension of women's traditional work in the home, so the ability to nurse was somehow innate and the entry requirements correspondingly low. Yet studies suggest that better educated nurses deliver higher quality care (Aiken 2003).

Although service users and the public have mixed feelings about the move to degree-level registration, they expect nurses and midwives to be well educated and competent as well as compassionate and caring. Degree-level registration of all new nurses is key to our vision and is essential to recruit talented people in a competitive, changing labour market. Degree programmes equip nurses and midwives to work better in many settings and roles, and enable them to draw on a wider repertoire of knowledge and skills, including the capacity to make complex assessments and clinical decisions and deliver therapeutic interventions in situations that are often unpredictable and emotionally charged.

Many nurses welcomed the move. 'In countries that already have degrees it seems to have worked well; it is a recognized profession and then there is parity between disciplines. It does a lot for the profile of nursing and for nurses' self-esteem – it makes them equal,' we heard in NHS South West.

The move should not be obscured or undermined by legitimate concerns about how the change will be implemented and its impact on the existing workforce. Many respondents told us that the entry gate to nursing and midwifery degree programmes should continue to be wide, not least to continue the professions' fine tradition of creating higher education and career opportunities for people whose background and prior education gave them few such chances. As a participant at our NHS West Midlands event said, 'We have to be careful that we don't narrow the recruitment pool into nursing and midwifery careers.'

The experience and expertise of diplomate nurses and midwives should continue to be respected. As a participant at our NHS London event told us, we must 'work with the current workforce to explain the change, and make sure existing staff understand that they are still highly valued.'

Suitable mechanisms and gateways must ensure access to degree programmes for those who wish to upgrade their existing diploma in nursing, and for health support workers who wish to proceed to a degree course. In particular there should be further development of prior educational and experiential learning opportunities including national vocational qualifications, foundation degrees and apprenticeships. There needs to be a clear pathway from no degree to degree level, we were told in NHS South East.

These messages need to be well publicized to the public, service users, nurses and midwives, and other health stakeholders throughout the period of transition, and the policy must be pursued vigorously to ensure that the majority of nurses in England become graduates in the next decade. Steering groups and other mechanisms should coordinate government, the NMC and other regulators, the NHS and other health and social care employers, universities, student and professional bodies, trade unions and service users' groups to enable effective implementation and ensure that:

- stakeholders work in partnership to deliver the change;
- the move to degree-level registration for all new nurses is fully implemented by 2013;
- public concerns about the impact of the move on safety, quality and compassion are fully addressed, including provision of accurate information, discussion of comparable experiences, and explanation of the expected benefits;
- advice and analysis are provided on the implementation and impact of the move before and beyond 2013 for new students and the existing workforce;
- the transition is smooth and successful, including specific steps to reassure and support the existing workforce and provide opportunities for relevant degree-level education to all who wish it, making full use of their prior and experiential learning;
- comparable experiences within and beyond the UK are studied to inform policy and decision-making.

Continuing professional development

The RCM told us the statutory framework for supervision of midwives should continue to ensure their practice is fit for purpose, and annual reviews should help them identify their development needs. We find these principles equally applicable to nursing, believing that the point of registration is the beginning of lifelong learning and career development. Currently all nurses, midwives and specialist community public health nurses on the NMC register must renew their registration every three years to remain eligible to practise. In response to the government White Paper on regulation (Stationery Office 2007), the NMC is expected to make arrangements for revalidation that will also cover the development of standards for higher levels of practice.

We support this lever to maintain nurses' and midwives' fitness to practise. Successful revalidation will require a stronger infrastructure for continuing professional development (CPD). Historically nurses and midwives have suffered from a lack of paid study leave, funding for course fees or access to CPD, especially compared with medicine. Some organizations see it as a soft target for savings, yet CPD is an investment in flexible, transferable skills and knowledge.

Students told us how they sometimes confronted a mismatch with the ideals and values that attracted them into the professions. They sometimes enter an alternative reality of values and prized behaviours such as getting through the work as quickly as possible; not getting involved with service users or families; and avoiding eye contact with people. Mentorship, preceptorship and clinical supervision are important forms of support that can help students handle this 'reality shock' and enable all staff to tackle poor practice.

As a participant in our NHS East of England event told us, 'We need to be enabled to focus time and support on students in the ward in the same way doctors do with medical students and junior doctors.' At the same event, we heard that students needed mentorship from qualified staff, 'but in reality those nurses/midwives are often very stressed, and staffing levels don't reflect the need to mentor to the optimum.' We welcome the Nursing Preceptorship Framework (Department of Health 2009), and the promise of additional funding to support it, as the foundation of a successful and fulfilling career, while remaining concerned about whether current staff numbers and skill mix will allow sufficient time for it to work effectively.

Marketing nursing and midwifery

The move to degree-level registration of all new nurses requires new recruitment strategies. As the RCN and others warned us, the ageing profile of the workforce, particularly in the community, threatens a mismatch between supply and demand that should be tackled through effective recruitment alongside other measures for retention and return. Nursing and midwifery must compete with other graduate occupations offering comparable satisfaction and rewards. Teaching, for example, is attracting a new generation of recruits through the Teach First campaign, and similar moves are under way in social work (Training and Development Agency for Schools 2009).

The public and professionals told us that more could be done to market nursing and midwifery as careers. A participant in our event in NHS South East called for 'the rebranding of nursing as a challenging, exciting, rewarding career that high quality school leavers, mature people, men would enjoy… there's leadership, research involved… that it's not just hospital wards and bedpans.' 'Publicize [a career in nursing or midwifery], big it up to something that children aspire to,' a service user told us at our Manchester event.

New stories of nursing and midwifery are needed to convey the messages in our vision for the future. They should place nursing and midwifery in the wider health care context, position them as opportunities to acquire degrees that integrate practice and theory, and paint an appealing picture of career opportunities as practitioners, managers, teachers, researchers and policy-makers, in settings ranging from homes, schools and prisons to hospitals, universities, government and regulators. The stories should raise awareness of nurses' and midwives' skills and knowledge among the public, policy-makers, health service leaders and other professionals, and challenge stereotypes that are often reinforced and perpetuated by some sections of the media (see Box 4.6.1).

The new stories should be told in distinct national and local campaigns to promote positive images of the professions and attract high calibre recruits, as proposed by the Council of Deans and others. We urge that the campaigns be fresh and innovative, learning from the mixed experiences of previous nursing and midwifery recruitment campaigns as well as successful image-based campaigns in other occupations. They should engage with schoolboys as well as schoolgirls, and with adults seeking a career change, including those from black and minority ethnic communities. Seeking a diverse mix of recruits will help ensure the workforce reflects contemporary society and that care is culturally competent. They should also target those who have left nursing or midwifery employment. Finally, the new stories should inspire the existing workforce to improve standards and seek learning opportunities.

Integrating practice, education and research

We have been struck by the importance of effective partnerships between the local NHS, universities and other agencies and sectors to achieve excellence in education, training, research and innovative practice. These are essential to ensure good student selection and support their education, development and wellbeing. Health innovation and education clusters, being established locally to strengthen these partnerships, provide important opportunities to rebalance the priority traditionally given to funding medical education and research, and to ensure that nursing and midwifery research and development is properly funded and utilized.

The move to degree-level registration will only succeed if there are sufficient and sustainable numbers of nursing and midwifery educators to respond to the challenges, including that described to us by a nurse at our NHS West Midlands event – 'I could never see the link between theory and practice when I was training and that needs to change.' We agree with the compelling calls to scale up their numbers, roles and support.

Most high-level practice roles require expertise in teaching and research, while teachers need to engage with practice and research. Clinical and academic career structures currently run on parallel tracks, but need to merge in collaborative roles and models: a number of organizations emphasised the need for greater mobility between careers and roles in health service delivery, teaching and research. Joint appointments and other mechanisms for easy movement between health employers and universities should be facilitated to develop clinical academic careers, as part of a new emphasis on clinical academic roles that can also 'facilitate and help students and newly qualified nurses manage tensions between theory and practice' (Maben 2008).

Further development of nurses' and midwives' research capacity is also essential. The initiative launched in 2009 by the National Institute for Health Research and the Chief Nursing Officer to fund master's degrees in research and doctoral and post-doctoral programmes is an important step towards the creation of a cadre of nursing and midwifery research investigators.

The gaps that we have identified point to the need for an urgent review to consider how to strengthen the integration of nursing and midwifery practice, education and research; develop the nursing and midwifery educational workforce; facilitate sustainable clinical academic pathways between the NHS and universities; and further develop nurses' and midwives' research skills.

Recommendations

Educating to care

To ensure high quality, compassionate care, the move to degree-level registration for all newly qualified nurses from 2013 must be implemented in full. All currently registered nurses and midwives must be fully supported if they wish to obtain a relevant degree. A relevant degree must become a requirement for all nurses in leadership and specialist practice roles by 2020. The Midwifery 2020 programme should consider whether a relevant degree should become a requirement for all midwives in leadership and specialist practice roles. There must also be effective revalidation, and greater investment in continuing professional development.

Marketing nursing and midwifery

Strong national campaigns must be launched to tell new stories of nursing and midwifery that inform the public, inspire the current and returning workforce, and highlight career opportunities. They must position the professions as popular choices for school-leavers, and boost the recruitment of high calibre male and female candidates of all ages and backgrounds.

Integrating practice, education and research

An urgent review must be conducted on how to strengthen the integration of nursing and midwifery practice, education and research; develop and sustain the educational workforce; facilitate sustainable clinical academic career pathways between the NHS, other health providers and universities; and further develop nurses' and midwives' research skills.

Box 4.6.1: Something like hairdressing?

'Nursing retains an inherited image which belongs to the late 19th century. The lady with the lamp, the ministering angel and similar visions linger in the mind.' The Briggs report reached this conclusion in 1972: nearly 40 years on, has the public image of nursing changed?

The 19th-century handmaiden still flits through the minds of many members of the public. Several studies conducted in 2008-2009 on behalf of the Department of Health, NHS Education Scotland, and the NHS strategic health authorities of London, West Midlands, and Yorkshire and the Humber tell a similar story – and make sobering reading.

This extensive research reveals widespread ignorance and a host of misperceptions, based on an outdated stereotype that is at best old-fashioned and at worst condescending. It positions nursing as downtrodden. Nurses are loved but not respected, and seen as victims of their vocation, without autonomy or authority. It is nasty, poorly paid, menial work that requires empathy but not expertise. The stereotypical nurse is overworked, underpaid, stoic, put-upon, passive and unambitious. She is also female – nursing is 'reserved for women'.

Typical comments included the following. 'A nurse is an assistant to the doctor – it's like a lower version of a doctor,' said a 15-year-old boy. 'I'd equate nursing with something like hairdressing; there are some skills involved but not too technical,' said a career adviser. A teacher thought nursing was 'generally not for those who want or could do a degree.' Parents said, 'I'm not sure you need to be a leader to be a good nurse… surely doctors have the final say anyway?'

Both the public and nurses felt that nursing's reputation had been adversely affected by the media – 'bad things are publicized, good things are expected.' As a result, they said, all nurses needed to work to maintain public respect and confidence.

Nurses themselves were unhappy with their public image. They thought they were seen as subservient and poorly skilled, and that standards were thought to be declining – views that they feared might become self-fulfilling prophecies.

These misperceptions undermine morale: even though nurses mostly felt their work was positive, rewarding and fulfilling, they found their public image negative, de-energizing and demoralizing.

The discrepancy between image and reality is also likely to affect recruitment. As Briggs put it, 'the familiar association of the nurse with pain, suffering and death and the tendency to place her (almost always "her" rather than "him") within the setting of a hospital impedes an understanding of the great variety of jobs nurses actually do' (Committee on Nursing 1972).

As NHS London concludes, there is a need to attract the right people to become nurses in order to maintain and promote high quality care; support and motivate current nurses; and encourage and enhance positive perceptions among other professionals, decision-makers and the public.

Part 5

Conclusion

Chapter 5.1 Standing up for quality
Chapter 5.2 Recommendations
Chapter 5.3 References
Chapter 5.4 About the Commission
Chapter 5.5 Site visits by the Commission

into the future

Chapter 5.1
Standing up for quality

Nurses and midwives are at the very heart of our care services. Because of this they must play the leading part in reform as we move towards health services that demand high quality care for all. I am therefore delighted to endorse this report, and support its recommendations as important steps to build on the foundations of the NHS Next Stage Review.

The Commission's work sharpens the focus on delivering high quality care that I advocated in 2008. *High Quality Care for All* sets out bold and ambitious plans for putting quality at the heart of the NHS. These plans were not drafted in the corridors of Whitehall but in our hospital wards and community teams, voiced by the nurses and midwives who contributed so passionately to the national road shows. This Commission report is the vital next step. It allows us to reflect again on nurses' and midwives' specific needs and contributions, and provides the ideas needed to ensure they have the right support and tools to deliver high quality care every time.

The enthusiastic and widespread participation in the Commission's engagement process, which reflected the approach of the Next Stage Review, showed the high level of public interest in nursing and midwifery. Once again, NHS strategic health authorities and many other stakeholders played a key role in helping front-line staff to get involved and have their say, and I applaud this.

Implementing *High Quality Care for All* is not easy but it has never been more important. As the Commissioners remind us, health services face major challenges in the coming years if they are to respond effectively to the needs of an ageing population, people with long-term illnesses and disabilities, and the impact of so-called lifestyle diseases. These challenges will continue to see nurses and midwives centre stage as key coordinators and providers of highly skilled care. This is how it must be, not just because we know it is what service users want, but because we know it makes a difference. The work of nurses and midwives with patients, other service users, carers and families will continue to be the front line of managing these conditions, improving health and maintaining the wellbeing of communities across the country.

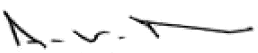
The number of expert nurses and midwives with the confidence, power and leadership skills to tackle these challenges will continue to rise. Front-line staff must work together with managers to retain and support the existing nursing and midwifery workforce. They are the public face of the professions and it is through them that the best calibre recruits will be attracted. This can only be done by investing in continuing education and development, and by the creation of good career pathways and opportunities for those new to the profession. Linked to this is the need to replace the old stereotypes of nursing with fresh public images.

Society rightly holds nurses and midwives in high regard, but that regard has not always been matched with supportive action by health leaders. There is no job more difficult than being a nurse or a midwife – and I speak as a surgeon. I only work effectively by being part of a well-functioning team led by my nursing colleagues. They bring expertise as well as compassion. The patients in our unit see the specialist nurse first for assessment, tests and sometimes diagnosis; this is just one example of how nurses are extending their roles in response to service users' needs, and making the best use of the health care team's resources.

I see in my own hospital front-line staff who want – and now increasingly feel they have – greater permission and encouragement to stand up for quality by challenging poor practice, leading improvements and delivering innovations. Clinicians, by whom I mean nurses and midwives as well as doctors and other professionals, are acting as the main agents of change, and we must continue to empower them and others to improve services.

Indeed, nurses and midwives throughout England are in the vanguard of adopting and promoting new ways of working – they have a tremendous appetite for innovation. Their closeness to patients and their families means they are well placed to identify where innovation is needed and then make change happen. Often, though, they lack the confidence to come forward with new ideas, or more likely meet little encouragement in implementing them. The culture of our organizations and teams should nurture their self-esteem and encourage them to lead change.

Changes of this magnitude cannot be left to nurses and midwives alone. They will not be made by someone else, somewhere else, but by all of us – nurses, midwives, doctors, surgeons, managers, policy-makers, politicians and the rest. We must work together to support front-line staff to deliver the high quality, compassionate care we want for our patients, families and ourselves, now and in the future.



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Chapter 5.2
Recommendations

The report makes 20 high-level recommendations on seven key themes:

- high quality, compassionate care;
- health and wellbeing;
- caring for people with long-term conditions;
- promoting innovation in nursing and midwifery;
- nurses and midwives leading services;
- careers in nursing and midwifery;
- the socioeconomic value of nursing and midwifery.

1 A pledge to deliver high quality care

Nurses and midwives must declare their commitment to society and service users in a pledge to give high quality care to all and tackle unacceptable variations in standards. The pledge complements the Nursing and Midwifery Council Code, the NHS Constitution and other professional codes and regulatory standards. Nurses and midwives must use it to guide their practice, adapting it to their work settings, and regulators and employers must ensure that their codes, policies and guidance on nursing and midwifery support it.

2 Senior nurses' and midwives' responsibility for care

All directors of nursing, heads of midwifery and other nurses and midwives in senior management roles must uphold the pledge, accept full individual managerial and professional accountability for the quality of nursing and midwifery care, and champion care from the point of care to the board. Directors of nursing must maintain clinical credibility and act with authority to ensure that their organizations enable high quality care. As board members they must be accountable for agreeing the shape and size of the nursing and midwifery workforce.

3 Corporate responsibility for care

The boards of NHS trusts and other health employers must accept full accountability for commissioning and delivering high quality care, ensure clear lines of accountability and authority for care throughout their organizations, and appoint a director of nursing to champion care at board level. They must ensure that their cultures and structures recognize and support directors of nursing and senior nurses and midwives to execute their responsibilities fully in relation to quality and safety.

4 Strengthening the role of the ward sister

Immediate steps must be taken to strengthen the linchpin role of the ward sister, charge nurse and equivalent team leaders in midwifery and community settings. These clinical lead roles must have clearly defined authority and lines of accountability and be appropriately graded. They must drive quality and safety, and provide active and visible clinical leadership and reassurance for service users and staff in all care settings. Organizational hierarchies must be designed to ensure there are no more than two levels between these roles and the director of nursing. Heads of midwifery should report to the board directly or via the director of nursing.

5 Evaluating nursing and midwifery

Gaps in the evidence base for the evaluation of nursing and midwifery must be clearly identified to determine what further research is needed, and further steps taken to commission, fund, disseminate and utilize research on their social, economic and clinical effectiveness.

6 Protecting the title 'nurse'

The Nursing and Midwifery Council must take urgent steps to ensure public protection and safety, and to allay current confusion about roles, titles and responsibilities, by protecting the title 'nurse' and limiting its use solely to nurses registered by the Council.

7 Regulating nursing and midwifery support workers

Some form of regulation of non-registered nursing and midwifery staff, including health care assistants and assistant practitioners, must be introduced to protect the public and ensure high quality care. The government and stakeholders must urgently scope and review the options, and recommend what type and level of regulation are needed.

8 Regulating advanced nursing and midwifery practice

The Nursing and Midwifery Council must regulate advanced nursing practice, ensuring that advanced practitioners are recorded as such on the register and have the required competencies. Stakeholders must also consider how to reduce and standardize the proliferation of roles and job titles in nursing. The Midwifery 2020 programme should consider whether midwives working in specialist and consultant roles need advanced level regulation.

9 Building capacity for nursing and midwifery innovation

Fellows should be appointed to promote nursing and midwifery innovation in service design and delivery, as champions of change and leaders of transformational teams that raise standards and embed innovation and excellence through peer review and support. Development of the entrepreneurial skills that nurses and midwives need to lead and respond to changing demands and innovative models of care must be included in pre- and post-registration education and training.

10 Nursing people with long-term conditions

The redesign and transformation of health and social care services must recognize nurses' leading role in caring for people with long-term conditions. Care pathways must be commissioned for service users that maximize the nursing contribution. Nurses must be enabled to make direct referrals to other professionals and agencies, and all barriers that prevent them from utilizing their full range of capacities and competencies must be removed.

11 Nurses' and midwives' contribution to health and wellbeing

Nurses and midwives must recognize their important role in improving health and wellbeing and reducing inequalities, and engage actively in the design, monitoring and delivery of services to achieve this. Commissioners of services must create incentives to encourage nurses and midwives to turn every interaction with service users into a health improvement opportunity.

12 A named midwife for every woman

The contribution of midwifery to delivering health and wellbeing and reducing health inequalities must be enhanced by organizing services so that every woman has a named midwife responsible for ensuring coordination of her care and providing support and guidance.

13 Staff health and wellbeing

Nurses and midwives must acknowledge that they are seen as role models for healthy living, and take personal responsibility for their own health. The recommendations of the NHS Health and Wellbeing Review (Boorman report) must be implemented in full, so that employers value and support staff health and wellbeing and thereby enable them to support service users.

14 Flexible roles and career structures

Commissioners and providers of education must ensure that nurses are competent to work across the full range of health and social care settings. Flexible career structures must be developed to enable them to move across settings within existing roles and when they change jobs.

15 Measuring progress and outcomes

The development of a framework of explicit, nationally agreed indicators for nursing must be accelerated, with the full engagement of front-line nurses. Further work must be done in midwifery to identify better indicators of outcomes, including service user satisfaction.

16 Educating to care

To ensure high quality, compassionate care, the move to degree-level registration for all newly qualified nurses from 2013 must be implemented in full. All currently registered nurses and midwives must be fully supported if they wish to obtain a relevant degree. A relevant degree must become a requirement for all nurses in leadership and specialist practice roles by 2020. The Midwifery 2020 programme should consider whether a relevant degree should become a requirement for all midwives in leadership and specialist practice roles. There must also be effective revalidation, and greater investment in continuing professional development.

17 Marketing nursing and midwifery

Strong national campaigns must be launched to tell new stories of nursing and midwifery that inform the public, inspire the current and returning workforce, and highlight career opportunities. They must position the professions as popular choices for school-leavers, and boost the recruitment of high calibre male and female candidates of all ages and backgrounds.

18 Fast-track leadership development

Regional schemes must be established to develop potential nursing and midwifery leaders, building on existing national work and learning from similar successful schemes in other sectors. They will identify talent, offer training and mentorship, and ensure that successful candidates who reflect the diversity of the workforce are fast-tracked to roles with significant impact on care delivery.

19 Integrating practice, education and research

An urgent review must be conducted on how to strengthen the integration of nursing and midwifery practice, education and research; develop and sustain the educational workforce; facilitate sustainable clinical academic career pathways between the NHS, other health providers and universities; and further develop nurses' and midwives' research skills.

20 Making best use of technology

A high-level group must be established to determine how to build nursing and midwifery capacity to understand and influence the development and use of new technologies. It must consider how pre- and post-registration education and development programmes could best deliver technological understanding and skills for information, communications and practice.

Chapter 5.3
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Chapter 5.4
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Chapter 5.5
Site visits by the Commission

The Chair, Commissioners and members of the Support Office made a number of site visits throughout England. They include the following:

Bevan Ward, Hillingdon Hospital, Hillingdon Hospital NHS Trust, Uxbridge

Cambridge Breast Unit, Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust

Central Surrey Health

Cockermouth Community Hospital and West Cumberland Hospital, North Cumbria University Hospitals NHS Trust

Defence Medicine Rehabilitation Centre, Headley Court, Surrey

Goodwin Development Trust, Hull

Great Ormond Street Hospital for Children NHS Trust, London

Great Western Hospitals NHS Foundation Trust, Swindon, Wilts

Guy's and St Thomas' NHS Foundation Trust, London

Heart of Hounslow Centre for Health, Hounslow Primary Care Trust, Middlesex

James Paget University Hospitals NHS Foundation Trust, Great Yarmouth, Norfolk

Liverpool Women's NHS Foundation Trust

NHS Great Yarmouth and Waveney

St Mary's Hospital, Imperial College Healthcare NHS Trust, London

St Mary's Stroke Unit, Hull and East Riding Stroke Service, NHS East Riding of Yorkshire

School of Human and Health Sciences, University of Huddersfield

Springfield Hospital, South West London and St George's Mental Health NHS Trust

Staffordshire University

Strength to Change Service, NHS Hull and Hull Citysafe

Sunderland Eye Infirmary, City Hospitals Sunderland NHS Foundation Trust, Tyne and Wear

Teesside University

The Queen Mary's Maternity Unit West Middlesex University Hospital NHS Trust

Trafford Healthcare NHS Trust and NHS Trafford, Manchester

University College London Hospitals NHS Foundation Trust

West Middlesex University Hospital NHS Trust

Front-line care: the future of nursing and midwifery in England 2010

This report from the Prime Minister's Commission on the Future of Nursing and Midwifery in England explores how the nursing and midwifery professions must take a central role in the design and delivery of 21st century services. It looks at nursing and midwifery today in the context of current socioeconomic, health and demographic trends, and dispels some myths and misunderstandings. It offers a vision of nurses and midwives in the mainstream of service planning, development and delivery, backed up by the necessary education, continuing professional development and supervision, and by supportive management and workplace cultures. It proposes 20 high-level recommendations on seven themes: high quality, compassionate care; the economics of nursing and midwifery; health and wellbeing; caring for people with long-term conditions; promoting innovation in nursing and midwifery; nurses and midwives leading services; and careers in nursing and midwifery.

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