Making a Difference

Strengthening the nursing, midwifery and health visiting contribution to health and healthcare
<table>
<thead>
<tr>
<th>chapter</th>
<th>page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>2</td>
</tr>
<tr>
<td>Preface</td>
<td>3</td>
</tr>
<tr>
<td>1 Making a difference</td>
<td>4</td>
</tr>
<tr>
<td>2 New nursing in the new NHS</td>
<td>7</td>
</tr>
<tr>
<td>3 Recruiting more nurses</td>
<td>18</td>
</tr>
<tr>
<td>4 Strengthening education and training</td>
<td>23</td>
</tr>
<tr>
<td>5 Developing a modern career framework</td>
<td>31</td>
</tr>
<tr>
<td>6 Improving working lives</td>
<td>36</td>
</tr>
<tr>
<td>7 Enhancing the quality of care</td>
<td>44</td>
</tr>
<tr>
<td>8 Strengthening leadership</td>
<td>52</td>
</tr>
<tr>
<td>9 Modernising professional self-regulation</td>
<td>56</td>
</tr>
<tr>
<td>10 Working in new ways</td>
<td>59</td>
</tr>
<tr>
<td>11 Making it happen</td>
<td>74</td>
</tr>
<tr>
<td>Early milestones</td>
<td>77</td>
</tr>
<tr>
<td>Delivering for nurses, midwives and health visitors</td>
<td>79</td>
</tr>
<tr>
<td>Associated publications</td>
<td>81</td>
</tr>
</tbody>
</table>
Foreword by the Secretary of State for Health

Wherever I go in our country most people have nothing but praise for nurses, midwives and health visitors. Their jobs are very demanding. Modern nursing, midwifery and health visiting is not just a matter of personal attention and tender loving care. Their jobs now require the operation of new high tech equipment and the application of new clinical techniques and new pharmaceutical products.

In Making a Difference we spell out what the Government is doing to recognise the value of nurses, midwives and health visitors. They need to be properly paid and properly looked after. And we have made a good start. This year we have implemented the biggest pay rise for 10 years for nurses, midwives and health visitors. That’s not all. We hope to introduce a new pay system which provides better rewards and removes the artificial ceilings to career advancement.

But important though pay is, it is only one element in our package of proposals to forge a new framework for nursing in the new NHS in line with changing patterns of care. We are recruiting more nurses. We are strengthening education and training. We are establishing a new career structure. We are introducing more family friendly working practices and improving safety in the workplace. We are developing leadership in nursing. And we are raising the quality of patient care.

Taken together, this adds up to a clear statement by the Government of the value it places on the contribution nurses, midwives and health visitors make to all our lives. We want to see more nurses in the NHS, providing the care they do for the people who need it. We want to see their work properly recognised. I believe Making a Difference is a testament to that, and to the vital help they give to everyone in our country.

The Rt Hon Frank Dobson MP
Secretary of State for Health

July 1999
Preface by the Chief Nursing Officer

Nurses, midwives and health visitors face a challenging future, but a future full of opportunities. Opportunities to make a positive difference to people’s lives and to have satisfying and rewarding careers.

The Government has launched a wide-ranging and ambitious programme of measures to improve the National Health Service and the health of the people of our country. The nursing, midwifery and health visiting contribution to these plans is absolutely vital. So it is important that nurses, midwives and health visitors are clear about what is expected of them and how they will be supported to help achieve the Government’s objectives.

Making a Difference explains the Government’s strategic intentions for nursing, midwifery and health visiting and its commitment to strengthen and to maximise the nursing, midwifery and health visiting contribution. But this needs to be matched by the personal professional commitment of every nurse, midwife and health visitor. I know that it will be.

I am delighted that in Making a Difference the Government has given such clear and unequivocal support for the work that nurses, midwives and health visitors do every day. I commend it to you.

Dame Yvonne Moores
Chief Nursing Officer and Director of Nursing
Making a difference

Key points:

- Nurses, midwives and health visitors are vital to the NHS, and to the nation: they make a real difference to people’s lives. People trust them, and have confidence in them. People value what they do. So does the Government

- The NHS employs over 332,000 nurses, midwives and health visitors. They provide care 24 hours a day, 365 days a year

- Nurses, midwives and health visitors are crucial to the Government’s plans to modernise the NHS and to improve the public’s health

1.1 Nurses, midwives and health visitors are vital: to patients, to hospitals, to the NHS, to health, to our nation. People rightly hold nurses, midwives and health visitors in high regard. They see them as forces for good in our society. They look to them, as well as to others in the NHS, for help at times often of great difficulty for themselves, and for their families. People trust them. They have confidence in them – in their skills, in their abilities, in their commitment. People see nurses, midwives and health visitors as important, as special, as vital. They are right to do so.

1.2 Nurses, midwives and health visitors are the largest of the health professions, and the biggest staff group in the NHS. They provide care 24 hours a day, 365 days a year. Their contribution is crucial to high quality care and treatment in the NHS, to the success of health promotion and illness prevention and to tackling inequalities and social exclusion.

1.3 We value what they do. We prize the contribution they make. We want to support that, and add to that. We want to ensure that nurses know that the value and service they give is appreciated – by the Government, and by the people. Patients, patients’ families, visitors, friends and others make that appreciation clear to nurses, to
midwives and to health visitors every day. They know the part that they play in improving their lives, and offering them care and support in sometimes dark moments for themselves and their families.

1.4 Nurses, midwives and health visitors in turn value that appreciation. For many of them, it is a central part of what they do. It encapsulates the best kind of public service values which they embody. Helping people – often people in trouble – caring for them, improving their lives, is for nurses, as for many other public service employees, a crucial element of why they do what they do. And they are doing this in a changing and increasingly sophisticated world.

1.5 We in government associate ourselves wholly with that appreciation. But while we share that perspective, we believe too that there is more that government can and must do to recognise that.

1.6 We value the contribution of nurses, midwives and health visitors. We want to improve their education, their working conditions and their prospects for satisfying and rewarding careers. We want to expand and develop their roles. We want them to be able to continue to take pride in working in the NHS. We want above all to enable them to continue to provide the exceptional care they do to people when they are at their most vulnerable.

In England the NHS employs 332,200 whole time equivalent nursing, midwifery and health visiting staff, three-quarters of whom (247,240) are qualified. Of these 18,170 are midwives and 10,070 are health visitors. 10,360 whole time equivalent nurses are employed in general practice. Nurses, midwives and health visitors work in hospitals, clinics, general practices, in the community and in workplaces. Following education and training leading to professional registration, many undertake further training to develop additional knowledge and skills or to work in specialist fields. All registered nurses, midwives and health visitors have to undertake continuing professional development to be able to renew their registration every three years.

1.7 We have ambitious plans for better health and a better health service: plans to improve people’s health and to modernise health and social services. The Government believes strongly that nurses, midwives and health visitors are critical to the success of these plans.
1.8 In our White Paper - The new NHS: Modern, Dependable – we made it clear that NHS Trusts would be expected to strengthen the nursing contribution. Many thousands of nurses, midwives, health visitors and others contributed to a national consultation exercise to help develop a new strategy for nursing, midwifery and health visiting.

1.9 Making a Difference sets out a new vision for the future of nursing in the National Health Service, and for people working as nurses, midwives and health visitors. It is a strategy for nursing which builds on what has worked in the past. It responds to the views and aspirations of those consulted. And it sets out action to tackle the challenges ahead.

1.10 Making a Difference aims to help nurses, midwives and health visitors respond positively to new opportunities and to establish the conditions for satisfying and rewarding careers. It provides strategic direction and integrates action with the wider modernisation and development agenda. It will help strengthen the contributions nurses, midwives and health visitors make. It reflects the feelings for, and the high regard with which, people across our country hold for those who do this vital work. It values and salutes the work they do. And it celebrates, promotes and advances the special place they hold in the life of the NHS, in the life of our country, in the life of our people.
New nursing in the new NHS

Key points:

- The context of care is changing. Nurses, midwives and health visitors face new challenges
- Nurses, midwives and health visitors are often constrained by structures that limit development and innovation
- Their contribution to the NHS and to improving people’s health must be strengthened and modernised
- ‘Making a Difference’ sets out our strategic intentions

The changing context of care

2.1 The context of care is changing. A new nursing, midwifery and health visiting strategy is needed to help nurses, midwives and health visitors respond to changes in society and in patterns of disease, to the possibilities created by developments in pharmaceuticals and technology, to increasing public expectations and to a challenging new policy agenda.

People’s health and social needs are changing

2.2 People are living longer, healthier lives. The number of elderly people in the population is rising. The demand for nursing care to help people with degenerative illness or disability – particularly to enable them to remain in their own homes and enjoy as much independence as possible – is increasing. The demand for support in the community for people with chronic and life threatening illness, or for those recovering from surgery or acute hospital care, will continue to rise.

2.3 Advising and supporting families and carers is an increasingly important part of the professional role. But traditional patterns of
family support will not be available to all. Geographical mobility is commonplace, 20% of families are one parent and 26% of households are people living alone. The most vulnerable – those without social networks, the socially excluded, the economically disadvantaged and some minority ethnic groups – are least likely to access and use services. Nurses, midwives and health visitors must be able to adapt their practice to reach and target these groups to make services and care more accessible.

2.4 Mortality rates for most major causes of death are higher amongst the poorest in society and morbidity is associated with unemployment, poverty, poor nutrition, and poor housing. There are significant geographical variations too. An integrated programme of measures across government is being put in place to tackle the root causes of avoidable illness. It brings together government, the public sector and business, local communities and individuals to plan and share responsibility for action. For many nurses, midwives and health visitors this means more and more working across organisational boundaries and with local communities to forge alliances and to develop innovative health strategies.

2.5 Trends in disease patterns point to a rise in chronic non-communicable diseases, in obesity and its consequences, in mental illness and to some new infectious diseases, and some well known old ones. These patterns have important implications for nursing, midwifery and health visiting. There will need to be increasing emphasis on integrated care, chronic disease management, disease prevention and on encouraging and supporting healthy lifestyle choices and self-care.

Technology is changing

2.6 An information revolution is taking place. The public is increasingly reliant on changing technology in many aspects of daily life. Around 15 million people in Britain – about 25% of the population – have a mobile phone. Personal computers are commonplace and the Internet has stimulated an information explosion, contributing to an increasingly well-informed public. By 1998 some 6 million people had used the Internet from home, a 76% increase on the previous year, and access and use continues to rise.
2.7 Modern health care will continue to benefit from changing technology. Electronic systems will be used to select and book hospital and clinic appointments. Health professionals will be able to access a national electronic library that includes the latest guidelines and evidence on which to base their clinical decisions. They will have access to electronic patient records and be able to request and receive test results at the touch of a button. Telemedicine and telecare will make screening, consultation, diagnosis and monitoring quicker, safer and more accurate, and care and treatment more effective. Images and data can be transmitted from distant sites to get expert opinion and advice, and to aid diagnosis and treatment decisions. Increasingly technology will help nurses, midwives and health visitors to take services and care to patients in their own homes, that would otherwise involve a clinic visit or hospital stay. NHS Direct – the 24 hour nurse-led helpline – has already demonstrated how simple technology can help improve access to information and advice.

Expectations are changing

2.8 The NHS has maintained public confidence in the face of increasing demand and rising expectations. This is due in no small part to the contribution of nurses, midwives and health visitors who are in the front line and perhaps the most visible part of the service. The quality of their relationships with patients and their families and the manner in which they handle concerns and complaints helps sustain public confidence in the NHS.

2.9 Public expectations continue to rise. In their daily lives people are no longer ready to tolerate waiting for services. 24 hour shopping and direct-line services mean instant access is the norm. People want accessible health care, delivered promptly and to a uniformly high standard. Our policies are designed to meet these expectations. Nurses, midwives and health visitors are central to our plans. They need to be prepared to respond to an increasingly well-informed public keen to have a bigger say in their care and treatment. People with chronic disease want to understand the course of their illness and to learn how best to manage it. Carers do not want to be the passive recipients of professional treatment but to work in partnership with nurses, midwives and health visitors.
2.10 Advances in medical science and biotechnology have led many people to think of high-technology hospital-based medicine as a panacea. Yet the majority of healthcare takes place outside hospital in people's homes and in clinics and surgeries. Nurses, midwives and health visitors have an important part to play not only in educating public expectations but also in improving access to services and ensuring patients benefit from care and treatment.

The NHS is changing

2.11 The Government has set out an ambitious programme to modernise the NHS and to improve the health of the population. We are building the future for the NHS - creating a new service which is modern - fit for the new century, and dependable - there when you need it. Our policies are directed towards:

- helping people to live longer and healthier lives;
- making sure everyone has fast, convenient and quality service whenever they use the service and wherever they live;
- giving the staff who work in the NHS the support, the buildings and equipment they need to provide a modernised service.

2.12 We set out plans to modernise the NHS in The new NHS: Modern, Dependable and supporting strategies in three subsequent publications: Information for Health, A First Class Service and Working Together. These policies represent a challenging ten-year programme of reform. We outlined our plans to raise the quality of social care in Modernising Social Services.

2.13 Nurses, midwives and health visitors are vital to delivering this bold programme of change. They are already playing key roles in establishing Primary Care Groups and Trusts, developing Health Improvement Programmes and service agreements and building integrated care pathways for patients. As the new NHS develops we want nurses, midwives and health visitors to play a central part in implementing National Service Frameworks, and securing quality improvement through clinical governance.

2.14 The new NHS is providing nurses with other new opportunities. NHS Direct, the 24 hour nurse-led helpline, has already shown that nurses can make a real difference to accessibility and has helped
people make informed decisions and use NHS services appropriately. For example, nearly three-quarters of callers have been advised to take a course of action different from the course they would have taken if NHS Direct were not available. 40 per cent of callers have been advised on how they can look after themselves at home. Nurses will also play a key role in new walk-in centres that will provide fast, flexible access to primary care. A new approach to services for the mentally ill at home, in the community and in residential settings is set out in Modernising Mental Health Services which will require a significant nursing contribution, in particular to support 24 hour nursed beds and outreach services.

2.15 Our health strategy for England, Saving Lives: Our Healthier Nation, sets out an action plan to promote health and prevent illness. The twin aims of the strategy are to:

- improve the health of the whole population by increasing the length of people’s lives and the number of years people spend free from illness;

- improve the health of the worst off in society and to narrow the health gap.

The White Paper sets national targets to reduce deaths from cancer, heart disease and stroke, mental ill-health and accidents. These will be backed up by local targets in each of these priority areas and to meet particular local needs, especially local health inequalities. Here too nurses, midwives and health visitors will have a vital part to play.

2.16 Smoking Kills sets out challenging plans to help people stop smoking. Nurses, midwives and health visitors are well placed to provide advice and support as part of their routine work with patients and clients, but also to develop strategies to target specific groups such as children and pregnant women.

2.17 We have established Health Action Zones in areas of deprivation to support and promote a multi-agency approach to health promotion, illness prevention and health provision and to break down traditional barriers between health and social care. Nurses, midwives and health visitors need to work with the wider community and across organisational boundaries to provide seamless care.
2.18 The Sure Start initiative and our policies to tackle health inequalities, to minimise social exclusion, to improve the social development of children within stable family backgrounds and to reduce the numbers of teenage pregnancies have significant challenges particularly for midwives, health visitors and school nurses.

Changing roles

2.19 Nurses, midwives and health visitors have a strong tradition of adapting to changes in society and of responding positively to new health care needs. Roles have been changing and developing. Nurses, midwives and health visitors are acquiring new knowledge and using their skills to the full to help improve access to services and to improve quality.

2.20 In primary care, practice nurses are now an essential part of the team helping to provide prompt, accessible care, running minor injury services, leading clinics and providing expert care and support to patients with chronic illness. Nurse prescribing is here to stay and Personal Medical Services pilot schemes have provided the opportunity to develop new ways of addressing primary care needs. Innovative schemes include pilots in Salford and in Derbyshire where nurses are leading the delivery of primary care services and employ salaried GPs. Elsewhere nurses have entered into partnership with GPs, working alongside them to provide the best range of services to meet the needs of the local population.

2.21 Midwives provide services across primary and secondary care boundaries offering integrated care in the setting most accessible and acceptable to the women in their care. This has done much to reduce the number of non-attenders at antenatal clinics. In other fields the interface between primary and secondary care is changing. Reductions in waiting lists have been possible because nurses have integrated care across sectors. In the community district nurses have expanded their skills to support earlier discharge and to prevent admission and re-admission. ‘Hospital at home’ and rapid response teams have been established. These have enabled people to remain in their own homes improving their quality of life and minimising the risks associated with being in hospital.

In Peterborough, a nurse-led rapid response team runs alongside a ‘hospital at home’ scheme to enable more people to be nursed at home. The team is able to respond to an acute crisis within two hours and can provide acute care for up to 72 hours. Referrals are accepted from GPs and hospitals and the team has access to diagnostic and medical support equipment enabling them to provide acute care in the home. Evaluation has shown that 71% of referrals would have been admitted to hospital if the service did not exist.
2.22 In other areas too nurses are making full use of their knowledge and skills. In wards and in accident and emergency departments, in endoscopy clinics and in mental health settings, nurses have acquired additional knowledge and skills and are developing their contribution to the multi-professional team to provide better services to patients. Nurses are working with medical and other colleagues to develop protocols to enable them to use their professional judgement, knowledge and skills more fully to benefit patients in their care.

2.23 Nurses, midwives and health visitors are also key players in the public health field and in helping to tackle inequalities and social exclusion. Health visitors are leading programmes to develop parenting skills and are working with local people to improve their health. School nurses are playing a vital role in equipping young people with the knowledge and skills to make healthy lifestyle choices. Midwives are tackling inequalities and social exclusion by targeting their advice and care, and are playing a key role in, for example, smoking cessation programmes to help expectant mothers. They can also play a crucial role in tackling domestic violence.

Constraints and limitations

2.24 The context of care is changing but nurses, midwives and health visitors are often constrained by structures that limit development and innovation. The NHS and wider health arena needs a modern and responsive workforce of well-motivated, well-trained professionals equipped to respond to the challenge of change.

Recruitment and retention

2.25 More people must be attracted into nursing, midwifery and health visiting. In recent years the NHS has suffered serious shortages of nurses and midwives and the workforce is ageing so the professions need to be refreshed and renewed. More nurses, midwives and health visitors are needed to deliver the Government's agenda for health and healthcare. They are needed in sufficient numbers not only to remedy shortages, but also to enable employers to offer the flexible working conditions expected of a modern service, and to offer nurses, midwives and health visitors the scope to provide care to the professional standards expected.
Education and training

2.26 Evidence suggests that in recent years students completing training have not been equipped at the point of qualification with the full range of clinical skills they need. Although this can be remedied relatively quickly, it undermines their confidence and can fail to meet the needs of a modern and demanding service. A stronger practical orientation to pre-registration education and training is needed. Access to education and training needs to be improved too. Although the nursing and midwifery professions have done more than many to improve access to higher education for both young people and mature students, entry is still too narrow. The NHS and health professions have failed to attract from as broad a range of applicants as they might. The professions still do not adequately reflect the communities they serve.

2.27 In the wider community, people are recognising that working practices and jobs have to change to keep pace with the contemporary world of work. Careers are no longer the planned and ordered vertical progression they once were. People have to train and retrain to maintain their competence to match current and future requirements. Lifelong learning is more than a slogan and access to education, training and development is no longer an aspiration for the few but a necessary part of jobs and careers in most sectors.

Pay and careers

2.28 The current clinical grading system is no longer appropriate for a modern health service. It has imposed unhelpful rigidities, created glass walls and ceilings trapping people and constraining career planning and progression. Automatic incremental progression has resulted in nurses and midwives getting stuck at the top incremental point with little prospect of further progression without a job change to gain promotion. Nearly 60% of those in E grade, 80% of those in G grade, 74% of those in H grade and 81% of those in I grade are at the top of their scales. The system has hindered rather than supported those who have taken career breaks, has failed to reward competence and satisfactory performance or properly to value clinical expertise. Some of the most expert and able nurses, midwives and health visitors who would prefer to remain in practice often see no alternative but to leave clinical work to advance their careers and earnings.
2.29 Many nurses, midwives and health visitors are content not to pursue continuing career progression through promotion or to undertake further formal education and training leading to new qualifications. They quite reasonably envisage horizontal careers which enable them to exercise their professional skills to the full by providing the best care possible, gaining satisfaction from making a real difference to people’s lives. But they want recognition for the expertise they acquire, for their personal investment in refreshing or developing their knowledge and skills, and for constantly striving to improve standards and quality.

Working lives

2.30 Increasingly people in all sectors of the community are combining careers with family commitments, and with continuing learning and development. Around 70% of the adult population of employable age live and work in two worker households. 89% of nurses, midwives and health visitors in the NHS hospital and community health services are women and only 66% of nurses, midwives and health visitors work full time.

2.31 For many nurses, midwives and health visitors, working arrangements, education and training and career development opportunities could be better structured to accommodate family, domestic and other commitments. There is often insufficient support for the continuing learning that is a necessary feature of modern professional practice. Those who work part-time sometimes feel undervalued and are denied the opportunities open to their full-time colleagues. Those who take career breaks consider themselves to be disadvantaged on return. Nurses, midwives and health visitors from black and ethnic minority groups are poorly represented in senior positions and may not have the same access to education, training and career development opportunities as colleagues with similar experience and qualifications.

Professional self-regulation

2.32 Strengthening professional self-regulation is at the heart of our plans to secure public protection, public confidence and to drive up quality in the health services. The current arrangements do not best serve the interests of public protection or the professions they regulate. A more open, responsive and accountable system is needed.
Better reflecting the communities served

2.33 Nurses, midwives and health visitors – both inside and outside hospitals – are an important part of local communities. Understanding and responding to local health needs and working with local communities will become an increasingly significant aspect of professional practice. Our new vision is of professions that better reflect the communities they serve, able to provide culturally sensitive and responsive services, care and support.

2.34 Perhaps more than any of the health professions, nursing, midwifery and health visiting have embraced diversity, drawing recruits from a variety of social, ethnic and academic backgrounds and encompassing a wide range of roles within the sphere of professional practice. Few other occupations can claim similar success in providing access to higher education or professional training for women. Yet there is still considerable scope to improve the working lives of all nurses, midwives and health visitors and to:

- achieve a better match between the social and ethnic composition of the professions and the communities they serve;
- secure equality of access to education, development and career advancement for nurses, midwives and health visitors from black and ethnic minority groups;
- provide education and training that encourages and accommodates broader entry, caters for those unable to commit themselves to full-time education, credits prior learning and provides for flexible, incremental progression.

An agenda for action

2.35 The challenges and opportunities of a changing world as well as the weaknesses in the current system highlight the need for a new strategy. If we are to realise the full potential that nurses, midwives and health visitors have to offer patients and the public we have to modernise working arrangements and improve access to and progression through programmes of learning and development. We also have to change attitudes and beliefs within and outside the professions. Inaccurate stereotypical media images of nursing need
to be countered. Prejudices within the health services that prevent or constrain the nursing, midwifery and health visiting contribution to decision-making need to be challenged. Working practices which fail to acknowledge the composition and needs of a modern professional workforce or to guarantee equality of opportunity must be contested.

2.36 In order to do that and to enable nurses, midwives and health visitors to respond to the way society and NHS is changing, action needs to focus on:

- recruiting more nurses;
- strengthening education and training;
- developing a new more flexible career structure;
- improving working lives;
- enhancing the quality of care;
- strengthening leadership;
- modernising professional self-regulation;
- supporting new roles and new ways of working.

2.37 Our plans in respect of each of these are set out in the chapters that follow. They provide a clear account of our strategic intentions. The development agenda is already very demanding. It is important to ensure that action to strengthen the nursing, midwifery and health visiting contribution is integrated into the wider capacity and capability building which is taking place. The developments we propose and the action we expect NHS organisations and others to take, will enable nurses, midwives and health visitors to face the challenge of change and to continue to make a difference to people’s lives.
Recruiting more nurses

Key points:

• A major expansion of the workforce is planned

• The NHS now has the capacity to take on up to 15,000 more nurses over the next 3 years

• 6,000 additional training places are to be made available over the next 3 years

• A sustained campaign to attract more people into nursing and to encourage qualified nurses, midwives and health visitors to come back to the NHS has been launched

• Improved systems of workforce planning at national and local level will ensure a better grip on future staffing requirements

3.1 The NHS needs more nurses, midwives and health visitors to address current shortages and to keep pace with the demands of providing faster, more accessible, high quality services to patients. It will get them.

3.2 All the evidence suggests that nursing remains a highly attractive career. In February this year we launched a high-profile, multi-media recruitment campaign to attract more people into careers in nursing, midwifery and health visiting and to encourage former staff to come back to the NHS. In 12 weeks the response was overwhelming. Over 53,000 calls were received on a telephone hotline from people interested in a career in nursing, or a return to nursing.

3.3 So the interest and the commitment is there. And so is the capacity for expansion. Extra money has been provided to ensure that up to 15,000 more nurses can be taken on over the next 3 years. This is the best current estimate of what is needed, taking account of existing staffing levels and other factors such as productivity and changes in skill mix. But the level of planned expansion will need to
be adjusted to keep pace with changes in service plans and better, more up to date information on staffing levels and requirements.

Recruitment into nursing careers

3.4 The NHS has been suffering from the previous Government’s decision to cut training places for nurses. Between 1992 and 1994 the number of training places available was reduced by 28%. The impact is still being felt in hospitals and practices around the country. But the tide has now turned. This year nearly 19,000 nursing and midwifery training places are planned, 4,000 more than three years ago, before this Government came into office. In all 6,000 extra training places will be available over the next 3 years. And this additional investment will be supported by a drive to reduce drop-out rates from courses. Variations in drop-out rates will be investigated and targeted improvements sought where necessary.

3.5 All the signs are that the national recruitment campaign, now backed by local initiatives building on its efforts, has succeeded in stimulating interest in nursing as a career. Applications to go on training courses are on the rise. NHS Careers, the new information service launched in April this year, will improve capacity to support and expand this level of interest.

3.6 Recruitment to the NHS has to begin in schools. Many local Health Service employers have positive contacts with local schools. Over 3,000 schools were recently involved in a national competition ‘Make some Noise – Tune Into the NHS’ in which entrants were invited to make a 40 second radio commercial on NHS careers. We will continue to build on these and other initiatives to raise the awareness of school children about careers in the NHS.

Schools Competition

Make Some Noise – Tune into the NHS

Jemma Culpin from Hamilton Community College, Leicester, won the 14-16 category for her radio advertisement about careers in nursing. She used the drama of a plane crash to highlight ‘all the good things nurses can do’, but her message was much broader and recognised the importance of every day life working in a hospital or the community. To Jemma, and to many of the competitors, nursing is a challenging and a valued career – ‘these few people make the decision to get involved, make the decision to change people’s lives’.
3.7 But it is not only school-leavers who want to train to become nurses, midwives and health visitors. Training needs to be more accessible for people seeking a second or third career, for people with family or other carer commitments, and for people already employed in the NHS who are seeking to build their careers or upgrade their qualifications. And, crucially, access to training must support the NHS commitment to diversity. We need hospitals and practices that reflect the communities they serve. Last year we committed ourselves to invest an extra £50 million over three years to support these aims, and the measures we are proposing to introduce more flexibility into nurse training which will further reinforce them.

Local NHS organisations in Bradford have developed:

- The Healthcare Apprenticeship Scheme – a national exemplar of the recruitment of black and ethnic minority entrants to nursing;
- The Jobshop – a bureau, located in a busy multi-cultural clinic, offering access to all NHS jobs in Bradford, as well as advice and support to those interested in working in the NHS. The jobshop was set up and is run by a multi-lingual Asian nurse.

3.8 Increasing the number of trained nurses, midwives and health visitors coming into the NHS is vital. But it will take time for the full benefits of the expansion of training numbers to come through. That is why a strong focus of the national recruitment campaign and local follow up action has been to attract former nurses, midwives and health visitors back to the NHS.

3.9 We know, from surveys, that four out of five nurses no longer working in the profession either intend to come back or might be persuaded to do so in the right circumstances. Top of the list of factors which would influence their return are personal support and accessible refresher training. Extra funding has, therefore, been made available to provide free return to practice courses.

3.10 The response has been very encouraging. Since the start of the national recruitment campaign:

- nearly 6,000 former nurses have approached their local Trust or education consortium about returning to the NHS;
• over 1,200 nurses have already returned to employment;

• over 2,800 former nurses are currently on return to practice courses or scheduled to attend them.

3.11 The national campaign has now ended. But the effort is being sustained at local level as employers build on the momentum created to run successful local campaigns. The NHS is the richer for the additional experience that returning staff bring to wards and practices. The success of the campaign so far confirms the potential for bringing more qualified staff back to the NHS to support an expanding workforce.

Mayday Healthcare Trust set up a 3 week return to practice course which has proved to be the Trust’s most successful recruitment aid. Attendance is free. Approximately 250 nurses have attended the course and about 165 have joined the staff of Mayday. After the last course – in March this year – 13 of the 16 participants have expressed an interest in working at the Trust and are being interviewed for posts.

Each three week course – which includes a week on the wards – is run in school hours (10am-3pm). There is no obligation to take up employment on completion. A certificate of attendance is issued. The 16 places on each course are always over subscribed. Each course costs about £4,000 to provide. All the lecturers are Trust employees.

The course has attracted returner nurses from a variety of specialist backgrounds, including intensive care, paediatric nursing and theatres, areas in which it is particularly hard to recruit.

The Trust provides a number of family friendly employment options including flexible working hours and shifts; night or day duty or internal rotation shift; bank, term time working; part time or full time hours; and full Whitley terms and conditions including paid holidays, sick leave, and compassionate leave for family emergencies. A workplace nursery is opening in September 1999.

Jane qualified as an EN, but left nursing some years ago. She was working as a medical receptionist when she saw the adverts from the national campaign. They made her think hard about getting back into nursing. She rang the national response line and through them got in touch with her local education consortium who were able to tell her about local opportunities to refresh and upgrade her skills. She started a conversion course in June and is looking forward to a renewed career in nursing.

Trained as a graduate nurse specialising in health visiting, Ruth had a 7 year career break to have a family. After doing a nurse refresher course Ruth and her family moved to Africa for several years. She used her nursing experience to undertake some pioneering work in primary health care. She set up an AIDS project in Tanzania and then went on to initiate and train local workers to run a health care project for street children. Ruth is now happily working in Manchester where her local primary health care team have really appreciated the wide experience she gained whilst out of UK nursing and the new skills she has to offer.
Improved workforce planning

3.12 The NHS needs a better overall grip on future staffing requirements. That means better systems for workforce planning at all levels and we have already announced our intention to review current workforce planning arrangements to ensure greater coherence and clearer lines of responsibilities and accountabilities.

3.13 The key is to ensure that thinking about services, the workforce and resourcing is joined up at all levels of the NHS: in an annual workforce plan at the level of the local organisation; in Health Improvement Programmes for local health economies; in National Service Frameworks. All these planning mechanisms should be used to maximise the contribution made by registered nurses, midwives and health visitors and to balance this with the part played by health care assistants, support workers and others. In some settings a richer skill mix will be required to achieve quality standards, cost effectiveness and the best health outcomes. In others support workers will be able to play a more significant role, subject to proper training and supervision.
Strengthening education and training

Key points:

- We will provide more career opportunities, from cadet to nurse, midwife or health visitor consultant, and more flexible approaches to nurse education and training
- Higher quality and longer placements, and better teacher support, will help students to gain better practical skills
- NHS leadership in nursing, midwifery and health visiting education and lifelong learning will be strengthened, with the Department of Health taking a more active and wider role
- A Partners Council will be established to provide a framework for post-registration education and continuing professional development

4.1 We aim to strengthen pre-registration education and training. The Prime Minister set out the Government’s plans in his speech to the Nurse 98 Awards. He said we need ‘a modern flexible system that enables and encourages people with different backgrounds and qualifications to acquire nursing skills and competencies in a flexible fashion’.

4.2 Nursing and midwifery pre-registration education takes place in partnership between universities and the NHS, underlining a shared commitment to preparing the largest professional group in the NHS. We need practitioners who are fit for purpose, with excellent skills, and the knowledge and ability to provide the best care possible in a modern NHS.

4.3 Overall the integration of nursing and midwifery education into universities has been a very positive move. At current participation rates 60% of school leavers can expect to enter higher education at some time in their lives. It is important that nurses, midwives and health visitors reap the rewards of learning alongside students of all subjects. However, there are also some concerns. Newly qualified
nurses and midwives are coming on to the wards without the full range of skills needed for effective practice. Universities and the NHS need to work more closely together and the NHS, as a major investor in education and champion for patients, needs to give a stronger lead to the universities.

4.4 The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) has established a Commission for Education chaired by Sir Len Peach. The Commission is due to report in September 1999. The Government has shared with the Commission its plans to improve nurse education and training. The Government’s priorities are to:

- provide more flexible career pathways into and within nursing and midwifery education;
- increase the level of practical skills within the training programme;
- deliver a nurse training system that is more responsive to the needs of the NHS.

We will work in partnership with the regulatory bodies, the universities and other key organisations to achieve these three goals and to strengthen practice-based teaching.

More flexible career pathways into and within nursing education

4.5 Widening access to learning is at the heart of our drive to create a learning society. We have to reach out to those who have been under represented in the NHS workforce: people from black and ethnic minority groups, people with disabilities, mature people, single parents.

4.6 The creation of more flexible career pathways will improve and widen access into education and create an NHS workforce more representative of the people it serves. We intend to provide more career opportunities, from cadet to nurse consultant, valuing and building on the contribution of health care assistants, tailoring education and training to individual needs and lifestyles.
Scenario A

Illustrative example of a possible route into nursing through a cadet scheme

Kylie left school at 16 with an Intermediate GNVQ in Health and Social Care. Undecided about a career, she had a number of jobs, mainly in nursing homes. This led her to consider nurse training, and after seeing an advertisement on the side of a bus she successfully applied for a place on a new nurse cadet scheme run by her local NHS Trust.

The scheme means that after a two year programme, based on NVQ qualifications, successful candidates are given a guaranteed interview for a nursing diploma place at the local university. Also, because of the knowledge, skills and experience gained during the two years of the cadet scheme candidates are able to ‘fast-track’ the diploma course, completing it within two years instead of the usual three.

During the first 2 months of the scheme Kylie spent most of her time observing and training, contributing little to direct patient care. After this period she spent about 3\(\frac{1}{2}\) days a week on placements in clinical settings with 1\(\frac{1}{2}\) days spent on academic and assessment activities, still within the Trust.

At the end of the second year Kylie achieved her qualification and gained one of the places set aside for cadets as agreed between the Trust, the local consortium and local university. The Trust seconded Kylie and she maintained links with a mentor at the hospital. On successful completion of her diploma she got a job as a Registered Nurse with the Trust. Now, one year later, she mentors two new cadets.

4.7 Individuals and the NHS will benefit from more flexible approaches to education and training. The plan is to strengthen the links between vocational training and pre-registration education, allowing people to take up a career as a qualified nurse later in life, after a spell working as a health care assistant. We also want to see more part-time training opportunities.

4.8 The main feature of this model will be ‘stepping on’ and ‘stepping off’ points. Health care support workers, with appropriate vocational qualifications will be able to fast-track nurse training. An individual on the traditional nurse education programme will be able to step
off, with credits, recognised by employers and educators alike, enabling them to work in the NHS as a support worker if they wish to, and return to nurse education at a later date.

**Scenario B**  
**Illustrative example of a possible route - stepping on and stepping off**  
14 months ago Meena started a three year nursing programme at her local university. Whilst she has been able to stick the pace, she feels that she is unable to do the course justice since her mother fell ill and she has had to look after her younger brother and sister. She still wants to be a nurse but now is not a good time to concentrate so she decides to leave.

She passed all the necessary assessments during the first year, so leaves with a qualification recognised by her employer which enables her to get a job at the local Trust as a senior health care assistant.

After a couple of years things settle down and although she has moved to a different part of the country, she has more time and wants to complete her diploma. She therefore applies to her local university to re-join a programme. Meena is successful, receives a bursary and completes the course 2 years later and joins the local NHS Trust as a staff nurse.

**4.9** This new model for nurse education will support the NHS in meeting its recruitment needs, and will reduce drop-out rates by providing students with an attractive alternative. But above all this model creates career pathways for cadets and healthcare assistants to progress ultimately to nurse, midwife or health visitor consultant. Many nurses will still train through the traditional three year diploma route, but it is important to widen the options to open entry to everyone.

**4.10** We propose that the new model of nurse education should commence in September 2000, in a minimum of 10 sites. The creation of vocational pathways into nurse education requires investment. We will, for example, support the development of a local network of vocational training centres. This will bring together the best practice in vocational training, to help the NHS form partnerships with education providers and Training and Enterprise Councils (TECs) to deliver National Traineeships, Modern
A pprenticeships and NVQ based training. This locally based consortium approach will give Primary Care Groups and Trusts access to the vocational training system resulting in better workforce planning and increased training opportunities for the wider workforce.

Better practical skills

4.11 Provision of clinical placements is a vital part of the education process. Every practitioner shares responsibility to support and teach the next generation of nurses and midwives. We want to get practical skills into education programmes from the start, so that students can get more hands-on experience more quickly, ranging from acute to community services. At present student nurses are supposed to spend 50% of their time gaining practical experience. We know that this is not always achieved, nor is the experience of the best quality. We want higher quality and longer placements in a genuinely supportive learning environment. EC Directives allow for more practical experience. We will consider this in the light of the UKCC Education Commission report.

4.12 It is important that, as with medical education, nurses are taught by those with practical and recent experience of nursing. To achieve this we will be setting clear targets for boosting teacher support for students on placements, and stepping up the pace of joint appointments with universities. There are many good models of lecturer-practitioners, and of clinical nurse specialists, that both benefit students and give experienced staff - such as ward sisters - the value of working in a learning organisation - a central plank of clinical governance. We intend to create more opportunities for experienced staff to combine teaching and patient care so that students can acquire better practical skills. We are also determined to enhance the status of those who provide practice-based teaching.

Making sure nurse and midwife training is responsive to NHS needs

4.13 This year alone the NHS will invest almost £800 million into the education and training of nurses, midwives and health visitors, and almost 19,000 new students are expected to enter nursing and midwifery education programmes. It is vital that the NHS gets full value from this investment and it is for this reason that the Department of Health will in future take more direct responsibility for the shape and direction of nurse and midwife education.
4.14 We are currently reviewing structures and processes for the better management of the majority of NHS funded education. Our proposals will be published shortly. The Department of Health will take on a more active and wider role. We want to strengthen the links between education and NHS employment, to ensure that the requirements of the NHS are put at centre stage in the development of all nursing and midwifery curricula and of continuing professional development. We want to give a kickstart to more multi-professional learning and teaching and to ensure the systematic sharing and spreading of good practice; and more effective and accountable stewardship for the NHS’s massive investment in education.

4.15 Department of Health responsibility for these functions will be supported by the establishment of a Partners Council to bring together stakeholders including the regulatory and professional bodies, universities, patient representatives and the NHS. The Partners Council will influence both pre-registration and ‘lifelong learning’ for nurses, midwives and health visitors. We are determined to modernise and strengthen self-regulation, to anchor lifelong learning more securely in the complex and rapidly changing needs of patients and to open up career pathways suited to the needs and values of individuals. All this highlights the case for more flexible mechanisms and structures for continuing professional development (CPD) for nurses, midwives and health visitors. Practitioners and employers are confused by the proliferation of courses and levels, and by the lack of clear links to career paths. That is why the Department must take on an enhanced role together with the new Partners Council, to ensure that practice development, education and research are joined-up, and a framework is provided for post-registration education and continuing professional development.

4.16 The NHS must also be more engaged with selecting and supporting students, valuing them as the lifeblood of the NHS in the years ahead. Students need to feel they have a stake in the NHS. Equally important, NHS employers must recognise that they have obligations to the students. They in turn need to know what to expect from the world of work. When we receive the results of Sir Len Peach’s report we will decide how best to strengthen the links between the later years of nurse education and the early years working as a registered nurse.
4.17 A nother key feature of the new system will be stronger and more effective working relationships between the NHS and the universities. The Department of Health will take the lead on assuring the quality of that education, working in partnership with the Quality Assurance Agency (QAA), and professional and regulatory bodies, as well as the universities.

4.18 The NHS also needs to know that nurses are trained to broadly the same standards and have the same skills - wherever they are trained. A consistent approach to pre-registration nurse education is also needed if we are to open up more flexible pathways into and within nursing careers. Threshold standards for entry to the profession are the responsibility of the UKCC, but we propose to agree outcomes for the end of each of the three years of the education programme in England to ensure that there is a greater consistency in the knowledge and skills that students have at the end of each year of the educational programme. We will also work in partnership with the statutory bodies, higher education and the QAA to develop nationally consistent benchmark standards for nursing and midwifery to ensure that nurse education provides well trained nurses equipped with the skills needed for the new, modern NHS.

Continuing professional development

4.19 The vision of continuous quality improvement and the introduction of clinical governance rests on a clear commitment to continuing professional development (CPD) and lifelong learning by both practitioners and NHS organisations. Working Together commits NHS organisations to the introduction of Personal Development Plans linked to performance appraisal and organisational objectives. In planning or providing CPD, NHS organisations should ensure that, besides fully involving the individual and other stakeholders, it is:

- purposeful and patient centred;
- targeted at identified educational need;
- educationally effective;
- part of a wider organisational development plan in support of local and national service objectives;
• focused on the development needs of clinical teams, across traditional professional and service boundaries;

• designed to build on previous knowledge, skills and experience;

• designed to enhance the skills of interpreting and applying knowledge based on research and development.

4.20 CPD programmes need to meet local service needs as well as the personal and professional development needs of individuals. Flexible approaches are required to better support changing roles and career pathways and to foster professional ownership. The learning that takes place at work through experience, critical incidents, audit and reflection, supported by mentorship, clinical supervision and peer review can be a rich source of learning. Work-based learning in multi-professional teams, making full use of modern technology can yield benefits for the individual, the organisation and the professions. The mandatory requirements for post-registration education and practice for nurses, midwives and health visitors are entirely consistent with this approach.
Developing a modern career framework

Key points:

• A new modern career framework is needed for nurses, midwives and health visitors

• It will be linked to the Government’s proposals to modernise the NHS pay system

• There will be three broad flexible ranges for registered nurses, midwives and health visitors, and a fourth for health care assistants and cadets

• Progression will be linked to responsibilities and the competencies needed to do the job

• The framework includes the new nurse, midwife and health visitor consultant posts which significantly extend career and pay opportunities – they will have the opportunity to earn around £40,000 per annum

5.1 This year we implemented the biggest pay rise for nurses, midwives and health visitors for 10 years. This was paid in full without staging. We gave a 12% rise to newly qualified staff - a starting salary of over £14,000 per year and over £17,000 in London. We accepted the Review Body recommendations in full. And our plans to establish nurse, midwife and health visitor consultant posts in the NHS will significantly extend the current upper limit. For the first time ever, the salary scale for nurses, midwives and health visitors who choose to remain in clinical practice will extend from the top end of the current clinical grading scale to around £40,000 per annum. Nurses, midwives and health visitors deserve to be properly rewarded for the jobs they do. But pay alone is not enough.

5.2 A new modern career framework is needed to help provide more satisfying and rewarding careers. We signalled our plans in Agenda for Change, which set out our proposals to modernise the NHS pay
system. Talks are underway with representatives of NHS unions and professional organisations. We aim to reach agreement on new national pay and conditions of service for all NHS staff.

5.3 A new career structure is proposed to replace clinical grades for nurses, midwives and health visitors. It will provide better career progression and fairer rewards for team working, developing new skills and taking on extended roles. It will also provide better opportunities to combine or move laterally between jobs in practice, education and research.

5.4 Our proposals for a new career framework incorporate the new nurse, midwife and health visitor consultant posts we announced last year. These posts will provide a new opportunity for experienced and expert nurses, midwives and health visitors who wish to remain in practice to do so. These posts significantly extend the career ladder enabling those nurses, midwives and health visitors who might otherwise have entered management or left the profession to advance their careers and improve their pay.

5.5 The posts will be structured to strengthen professional leadership, and will be designed around plans to help provide better outcomes for patients by improving services and quality. We will issue guidance about establishment of nurse, midwife and health visitor consultant posts shortly.
Nurse, midwife and health visitor consultant posts will be established in the NHS to help improve quality and services; to provide a new career opportunity to help retain experienced and expert nurses, midwives and health visitors who might not otherwise remain in practice; and to strengthen professional leadership. Nurse, midwife and health visitor consultants will have responsibilities in four main areas: expert practice; professional leadership and consultancy; education and development; and practice and service development linked to research and evaluation. The weight attributable to each of these areas will vary from post to post depending on the particular needs and service in which they are established. But all posts will be structured to enable at least half the time available to be spent in expert nursing, midwifery or health visiting practice in contact with patients and clients. The new posts will provide a significant opportunity to help shape services in line with Government policies to improve health and health care.

Salaries for nurse, midwife and health visitor consultants will range from around £27,000 to around £40,000 per annum. The exact pay band for individual nurse, midwife or health visitor consultants within that range will, as set out in Agenda for Change, be related to responsibility, competence and satisfactory performance.

It will be for NHS Trusts to establish the number and scope of nurse, midwife and health visitor consultants they wish to employ. However, they will be required to consult with Regional Offices so that local innovation and experience in this new area is shared around the health services and a broadly consistent approach is applied across the NHS.

5.6 If the new pay proposals are agreed, there will be three broad flexible ranges for registered nurses, midwives and health visitors. There will be clear minimum pay thresholds for each of these, set nationally. The pay for each post would depend on its responsibilities, and progression within each range would depend on competencies required to do the job and on satisfactory performance. We want people to be rewarded for the job they do. We want nurses, midwives and health visitors to engage in continuing professional development linked to clinical governance and to develop their knowledge and skills to meet defined patient and service needs.
5.7 An important part of the overall career structure will be nursing and midwifery cadets, health care assistants and clinical support workers in a fourth range; many of whom will undertake vocational qualifications as part of our approach to lifelong learning. We plan to widen entry into professional education for these groups, to provide stepping on and stepping off points during training, and to provide the opportunity for progression from cadet to nurse, midwife or health visitor consultant.

5.8 We will work with professional organisations and trades unions and the UK Health Departments to develop clear statements of competence identifying the thresholds to each range. But it will be for local NHS employers to develop more detailed competency frameworks to enable career and pay progression within each range following nationally agreed guidance. Progression within each range and through thresholds to the next range will be supported through personal development planning, continuing professional development and other training.

5.9 The table below provides a broad overview of our plans. It provides an indication of the direction our more detailed work with key stakeholders will take. It is not intended to be comprehensive and is for illustrative purposes only. It does not and cannot illustrate the great diversity of jobs, detailed competencies and specific training required within each range, nor the more general continuing professional development which all nurses, midwives and health visitors should undertake to maintain their competence.

5.10 For example, the second range might encompass the newly qualified nurse who is consolidating experience as a member of a community team or surgical ward, but also the experienced nurse who has undertaken additional specialist training and is working in intensive care. Using the spine points covering each range, local competency frameworks will enable employers to recognise and reward the responsibilities of the job and the professional competencies required to do it.

5.11 Our plans to replace clinical grades are part of wider negotiations, which also cover other issues and all NHS staff. They will be introduced only as part of an overall agreed programme of change.
## A new career framework for nurses, midwives and health visitors

<table>
<thead>
<tr>
<th></th>
<th>Typically people here will, at a minimum, be competent...</th>
<th>Typically posts will include...</th>
<th>Typically people here will have been educated and trained to...</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>... to provide basic and routine personal care to patients/clients and a limited range of clinical interventions routine to the care setting under the supervision of a registered nurse, midwife or health visitor.</td>
<td>... cadets and health care assistants and other clinical support workers.</td>
<td>... National Vocational Qualification levels 1, 2 or 3.</td>
</tr>
<tr>
<td>II</td>
<td>... to do the above and exercise clinical judgement and assume professional responsibility and accountability for the assessment of health needs, planning, delivery and evaluation of routine direct care, for both individuals and groups of patients/clients; direct and supervise the work of support workers and mentor students.</td>
<td>... both newly registered nurses and midwives and established registered practitioners in a variety of jobs and specialities in both hospital and community and primary care settings.</td>
<td>... higher education diploma or first degree level, hold professional registration and in some cases additional specialist-specific professional qualifications.</td>
</tr>
<tr>
<td>III</td>
<td>... to do the above and assume significant clinical or public health leadership of registered practitioners and others, and/or clinical management and/or specialist care.</td>
<td>... experienced senior registered practitioners in a diverse range of posts including ward sisters/charge nurses, community nurses, midwives, health visitors and clinical nurse specialists.</td>
<td>... first or masters degree level, hold professional registration and in many cases additional specialist-specific professional qualifications.</td>
</tr>
<tr>
<td>IV</td>
<td>... to do the above and provide expert care, to provide clinical or public health leadership and consultancy to senior registered practitioners and others and initiate and lead significant practice, education and service development.</td>
<td>... experienced and expert practitioners holding nurse, midwife or health visitor consultant posts.</td>
<td>... masters or doctorate level, hold professional registration and additional specialist-specific professional qualifications commensurate with standards proposed for recognition of a 'higher level of practice'.</td>
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Improving working lives

Key points:

• NHS-wide standards for the implementation of supportive, family friendly policies will be developed and NHS employers will be kite marked against them. A national campaign, spear-headed at regional level by multi-professional taskforces, will raise awareness, share good practice, champion improvements, provide practical support for implementation on the ground by front line staff and managers, and report progress.

• Nurses, midwives and health visitors should be involved in all decisions that affect their working lives – from big change programmes to day to day decisions on how services are delivered.

• NHS employers are being required to tackle discrimination and harassment in the workplace and to make targeted reductions in workplace accidents and violence against staff.

• Local annual staff surveys will act as a benchmark against which to measure improvements to the quality of working life.

6.1 Improving the quality of working life for NHS staff is one of the Government’s key strategic aims. It is directly linked to our commitment to improve the quality of services offered by the NHS. Building modern, dependable services depends on the skill and dedication of NHS staff. Quality of care goes hand in hand with the quality of working lives for nurses, midwives and health visitors. Working Together, the new national framework we have established for managing staff in the NHS, sets challenging priorities and targets for employers to ensure that the NHS becomes a better place to work.

Modernising working conditions

6.2 As traditional family life and career patterns change, nurses, midwives and health visitors are looking for a better balance between work responsibilities and other demands and needs.
The majority of nurses, midwives and health visitors are women. Women continue to be the majority of primary carers. Far more has to be done at all levels in NHS organisations to make sure that working conditions enable all staff to feel in greater control of their working lives, not only as parents, or as carers, but also in order to maintain a healthy lifestyle and to be able to play a full part in the wider life of their local neighbourhood and community.

### 6.3 The Government has set the pace with a major programme of modernisation in employment relations, human rights and family policy.

- We have developed a tax and benefits package to support families.
- The Employment Relations Bill takes forward the Government’s proposals in the Fairness at Work White Paper, including simplified and improved maternity rights, time off for domestic crises and three months parental leave.
- The Government is implementing the Working Time, part-time and parental leave directives.
- It has launched a national carers strategy.
- The first ever national childcare strategy is underway to improve the quality, affordability and accessibility of childcare in every neighbourhood.
- The Government is tackling discrimination on age with its new Code of Practice on Age Diversity.
- It has accelerated progress on implementing disability rights so that people with disabilities can access services fully but also take up or stay in employment.
- Following consultation about our policy to support families, the Government will be launching a major national campaign to bring together employers to promote family friendly and flexible working practices.
6.4 All these changes are fundamental to improving the quality of working life. They will make a difference to all staff working in the NHS. And there is already much on which to build. Many NHS organisations have already developed innovative patterns of working that match the needs of patients and carers with the preferences of staff. Many NHS managers have worked with staff to build supportive, flexible working arrangements that reconcile personal and professional commitments. The Working Lives resource pack, launched earlier this year, illustrated good practice examples of this kind as an aid to local initiatives.

6.5 But a step change is needed to ensure that a recognition of the need to modernise working conditions is translated into action on the ward, or in the local practice, right across the NHS. A high level national campaign will now be launched, built around three key features:

- **the development of comprehensive standards for the implementation of family friendly policies, against which the performance of local organisations can be measured.** A kite marking system will also be developed to ensure that local organisations who perform well against the standard are recognised, and to enable progress across the NHS to be monitored. As a first step, a draft set of principles outlining the values and characteristics of an NHS organisation committed to these policies will be published for consultation. This will form the basis for the development of comprehensive standards;

- **effective communications to raise awareness, to promote modern, flexible employment practices and to share good practice.** A programme of activity is planned at national, regional and local level. Further Working Lives resource packs will be made available. Beacons of good practice promoting flexible working lives have already been recognised, as part of the Government’s programme to support learning and sharing best practice in the NHS; and they will be used to promote and support the overall campaign;

- **practical support for effective implementation on the ground by front line staff and managers.** Tool kits for staff managers are being developed, covering such issues as the use of self rostering schemes – with and without IT support; developing effective childcare arrangements; and the management of study leave,
career breaks and secondments. A joint NHS/retail sector project, led by the Women’s Unit, involving individuals and organisations from the NHS and the retail sector, is leading much of this development work.

Chelsea and Westminster Healthcare - A Beacon NHS Trust
Chelsea and Westminster Healthcare Trust won their Beacon status for a Trust-wide initiative to recognise that their staff are their most valuable resource. As part of their commitment to improve working lives they have developed the Employee Pledge. This sets out the standards that all employees can expect from the Trust and from their manager. It reflects the Trust aims – to treat staff fairly, to develop them and to recognise their contribution – and is part of the Trust’s wider Partnership Pledge to improve services for patients and carers, and contribute positively to the community and environment.

The Employee Pledge was developed with the help of staff who were interviewed about their concerns. It commits the Trust and managers to:

- support staff in balancing work and home commitments;
- discuss and make readily accessible information on Trust business;
- provide access to an independent support service offering confidential counselling and advice.

Each Directorate has identified a Pledge promoter who undertakes to facilitate workshops that every manager in the Directorate attends. These provide guidance on how to meet the Pledge, including,

- how to put into operation family friendly policies;
- how to support those returning to work;
- different ways of developing staff;
- creating a dialogue with staff.

Each Directorate has an action plan for meeting the Pledge. Progress is monitored and the impact of the Pledge on staff will be evaluated each year. The first evaluation showed good progress in tackling the areas staff had been most concerned about – for example 100% of staff interviewed said their manager had supported them on their return to work.
6.6 This campaign will be led and co-ordinated at national level by the new Recruitment and Retention unit in the National Health Service Executive emphasising the importance of maintaining and expanding the NHS workforce of the future. But multi-professional taskforces will be appointed in each of the NHS regions to champion improvements, spread good practice and monitor progress. A senior nurse, midwife or health visitor will be appointed to each of these taskforces; and they will be expected to work with colleagues in these professions to ensure that the campaign is translated into effective action on the ground.

Equality in the workplace

6.7 The campaign to modernise working practices in the NHS and to give staff more control over their working lives, will directly benefit women, who form the majority of nurses, midwives, health visitors and other carers. But equality in the workplace has to go further. Women still face discrimination in the workplace and in progressing their careers. Racism is still pervasive. Black and ethnic minority nurses make up just under 8% of the workforce whereas fewer than 1% of Directors of Nursing are from black and ethnic minority communities. Nearly 25% of nurses over 55 are black or Asian whereas fewer than 3% of nurses under 25 are from black and ethnic minority communities. This almost certainly reflects a reaction to discrimination suffered by many of the older black and ethnic minority staff in the NHS.

6.8 The response of employers to disability has often been insensitive and unimaginative but the introduction of NHS Direct provides new opportunities.

6.9 We are determined to make equality in the workplace a priority for NHS employers. Reducing inequalities in health care is one of our principal objectives in modernising the NHS. The values we are seeking to embed in service provision must also be reflected in the way staff are treated. Later this year, we will publish the first equal opportunities framework for the NHS. It will set out priorities and a programme of work to give direction and support to NHS employers in complying with the statutory framework, to help them reach the standards of the best in treating all staff fairly, and in removing discriminatory barriers and tackling harassment. The framework will be supported by equality standards, indicators and performance management measures that spell out good practice and monitor outcomes.
6.10 Local NHS employers have already been required to have policies and procedures in place for combating harassment, supported by monitoring and reporting arrangements to measure progress. And a major national programme of action to tackle racial harassment in the NHS was launched in 1998. It is being taken forward with the contribution and participation of nurses, midwives and health visitors. It is targeted on the experience of staff working in the community as well as in hospital settings. Plans and development work are designed to bring about real change and support for staff, recognising the real risks and conflicts that arise for staff providing primary care, especially to vulnerable people.

Staff involvement

6.11 We are determined to ensure that all NHS staff are effectively involved in the decisions that affect their working lives. We appointed a national taskforce, with representatives from across the NHS workforce, including two front line nurses, to look at best practice in this area in the NHS and outside and to make recommendations for the effective implementation and performance management of staff involvement across the NHS.

6.12 The message of the taskforce is clear. Where staff are involved they feel valued and make a better contribution to service delivery. Where they are not, it is not just the staff who lose out. Patient care suffers. The evidence shows that employers in the NHS – and outside – who involve staff in decisions, planning and policy making will deliver better services, manage change more effectively and have a healthier, better motivated workforce and reduce staff turnover.

6.13 The taskforce has made a number of practical recommendations for embedding staff involvement in the NHS; and we are committed to publishing an action plan to take forward those recommendations in the autumn.

Healthy workplaces

6.14 Improving working lives also means creating safe and healthy working environments that support and protect nurses, midwives and health visitors doing physically and psychologically demanding jobs. A national framework for action is being developed, which
picks up on the challenge issued to the public sector in Managing Attendance in the Public Sector – Working Well Together. Trusts and Health Authorities are being asked to work towards reducing sick absence and accidents at work, by 20% by 2001 and 30% by 2003. The good practice guidance is being commended across the NHS, which has been asked to tackle back injuries, which nurses are particularly vulnerable to, by for example, further emphasis on lifting and handling training, and fast-track physiotherapy services. In addition, variations in sickness absence has been selected as a project area by the Public Services Productivity Panel. This will examine successful approaches to sickness absence management. Improving access to occupational health support and advice is also a key area for early attention.

6.15 Violence and intimidation at work is worrying and a real concern for many nurses, midwives and health visitors. Local Trusts have already been required to prepare strategies for reducing violence against staff, and encouraged to participate in local crime reduction partnerships. The Lord Chancellor has given a clear steer to Magistrates that the Government believes violence against nurses, midwives, health visitors and other staff is completely unacceptable, particularly the perverse notion that it goes with the job. Violence committed against someone carrying out their NHS duties should be seen as an aggravating factor when sentencing an individual for such an offence. All this is being augmented by a cross-Government drive to tackle violence against staff working in the NHS involving the Home Office, the Lord Chancellor’s Department, the Crown Prosecution Service and the Attorney General’s office, as well as the Department of Health. The campaign has two principal messages: to make crystal clear to the public that violence against staff working in the NHS is unacceptable and the Government is determined to stamp it out; and to reassure staff that violence and intimidation will not be tolerated and is being effectively tackled. A publicity campaign will be underpinned by national targets to reduce the incidence of violence by 20% by 2001 and 30% by 2003, and will be supported by a resource pack to help local managers draw up action plans.

6.16 One of the places where nurses are most vulnerable to attack is in Accident and Emergency Departments. The Government is spending over £100 million modernising every casualty department that needs it. Improved safety and security for staff, with better
design and closed circuit TV, is a feature of many of the plans in those places where threats to staff are a particular problem.

Staff surveys

6.17 Progress against all these priorities and initiatives will be monitored under the Working Together framework. But it is essential that local organisations measure the quality of working life for staff; and they have all been required to carry out annual staff surveys for that purpose, including surveys of staff attitudes.
Enhancing the quality of care

Key points:

- The Government’s plans for quality improvement in the NHS are built around clear national standards, ensuring and monitoring local delivery through clinical governance, supported by professional self-regulation and continuing professional development.

- Nurses, midwives and health visitors must play a full part in developing and implementing national service frameworks and clinical governance.

- They need to focus on the quality of fundamental and essential aspects of care. Clinical practice benchmarking is one way to do this.

- Practice needs to be evidence based. Research evidence will be rigorously assessed and made accessible. Nurses, midwives and health visitors need better research appraisal skills to translate research findings into practice.

- A strategy to influence the research and development agenda, to strengthen the capacity to undertake nursing, midwifery and health visiting research, and to use research to support nursing, midwifery and health visiting practice will be developed.

7.1 We set out our detailed proposals for a new focus on quality in A First Class Service. Our aim is to develop a National Health Service that strives continuously to improve the overall standard of clinical care, to reduce unacceptable variations in practice and to ensure patient care is based on the most up-to-date evidence of what is known to be effective. The main elements of the new approach are:

- arrangements for setting clear national quality standards through National Service Frameworks and the new National Institute for Clinical Excellence;
• mechanisms for **ensuring local delivery** of high quality clinical services through clinical governance, reinforced by a new statutory duty on quality and underpinned by lifelong learning and professional self-regulation;

• effective systems for **monitoring delivery** of quality standards in the form of a new statutory Commission for Health Improvement and the new National Performance Framework and national patient and user survey.

The relationship between these elements and what they mean for patients is shown in the diagram below.

7.2 We want nurses, midwives and health visitors to play a full part in every aspect of our plans for quality improvement. We will ensure:

• they continue to be properly represented in the work of the National Institute for Clinical Excellence;

• nursing, midwifery and health visiting knowledge informs the development and delivery of National Service Frameworks;
• the work of the Commission for Health Improvement is properly informed by expert nursing, midwifery and health visiting knowledge.

7.3 National Service Frameworks (NSFs) will:

• set national standards and define service models for a defined service or care group;

• put in place programmes to support implementation;

• establish performance measures against which progress within agreed time-scales will be measured.

Each NSF is being developed with the assistance of an expert reference group which brings together health and social care professionals, service users and carers, health and social service managers, partner agencies, and other advocates. Building on cancer and children's intensive care, the first two NSFs will be for coronary heart disease and mental health, followed in 2000 by older people and, in 2001, diabetes. Nurses, midwives and health visitors will need to play their part in the development and the delivery of NSF standards.

7.4 Clinical governance is at the centre of our plans for quality improvement. It is being implemented throughout the NHS, in Health Authorities, Primary Care Groups and in NHS Trusts. Implementation will require a significant shift in organisational culture, strong leadership and the commitment of all clinical staff. We want nurses, midwives and health visitors to play a full part in its implementation.

7.5 The nursing, midwifery and health visiting professions have already developed a strong quality orientation, focussing on standards development, monitoring and audit methodologies and increasingly on evidence-based practice. Their practice has been guided by professional self-regulation, supported by clinical supervision and statutory midwifery supervision, and by the continuing professional development associated with mandatory periodic re-registration. These activities need to be developed, strengthened and integrated into the wider clinical governance development programme and linked to annual appraisal and personal development planning.
7.6 In some organisations nurses have been identified as the lead clinician for clinical governance. In others they are full partners in the implementation process. But in other places their involvement has been limited. It is essential that nurses, midwives and health visitors play their part in the preparatory work which is taking place now. They need to understand and contribute to the work to:

- establish a baseline assessment of capacity and capability;
- clarify reporting arrangements;
- formulate development plans;

...to ensure the nursing, midwifery and health visiting contribution to standards of care and treatment is reflected in local plans.

Clinical governance development plans

Implementing clinical governance is a joint responsibility. Every nurse, midwife and health visitor must play their part in partnership with the organisation and team in which they work. In particular, they need to match the continuing professional development they undertake as part of the requirement for periodic re-registration with local plans to improve quality.

When assessing capacity and capability as the basis for clinical governance development plans, NHS organisations need to consider a number of issues to ensure that plans respond to the development needs of nurses, midwives and health visitors to enable them to:

- fully understand local clinical governance implementation plans and important milestones;
- improve their information and research appraisal skills so they can use the best available evidence to support their practice;
- access guidelines and clinical information - especially where they are working away from main hospital sites - to support care and treatment decisions and to audit and improve practice;
- participate in regular appraisal and personal development planning;
- agree training and development needs and plan continuing professional development to match personal and professional aspirations with the needs of the NHS;
7.7 Where it is needed, nurses, midwives and health visitors should play their part in helping shift the culture of the teams and organisations in which they work. Clinical governance is about openness, admitting and learning from mistakes to prevent reoccurrence, rather than the culture of blame that exists in some organisations where mistakes are concealed for fear of the consequences. Our plans for a more systematic approach to clinical leadership will help Sisters, Charge Nurses and other team leaders to create the sort of climate in which learning and quality improvement becomes the norm, including learning from mistakes.

7.8 For nurses, midwives and health visitors, the first steps to implement clinical governance are likely to take place within the teams in which they work and to focus on the essential foundations of practice. For example, reflecting on and discussing the obligations associated with professional self-regulation and accountability will help focus attention on personal responsibility. Examining the quality of patient records and communication within the team – especially during handovers – might highlight fundamental areas for improvement. And looking critically at
Clinical policies and procedures could highlight deficiencies such as a lack of regular review, the absence of underpinning evidence or a failure to use approved clinical practice guidelines. Some teams have identified a lead person – or ‘guardian’ – to take special responsibility for searching out guidelines and evidence relevant to the areas of practice, and ensuring it is disseminated within the team – championing evidence based practice locally. It is basic first steps such as these that will provide the foundation for more sophisticated audit, monitoring and quality improvements in the longer term.

7.9 Clinical governance offers NHS organisations and nurses, midwives and health visitors a powerful means of addressing unacceptable variations in standards of care. Reports by the Health Advisory Service and Health Service Commissioner have drawn attention to poor standards. In some cases fundamental and essential aspects of care, including basic hygiene and mouth-care, tissue viability, nutrition, continence, privacy, dignity and the safety of people with mental illness, have been identified as falling below acceptable standards. Yet these are considered to be core elements of the nursing function and are crucial to patient well-being and recovery.

7.10 Preventing these lapses – by making standards explicit and by monitoring and seeking to improve practice – is an important part of clinical governance. Benchmarking is one approach that has proved successful in a project to improve the nursing care of children in hospitals. It is a process through which best practice is identified and continuous improvement pursued through comparison and sharing. We will:

- explore, with the nursing, midwifery and health visiting professions, the benefits of benchmarking to examine whether it provides the best means of supporting our vision to refocus on the fundamental and essential aspects of care.

But it is also for every nurse, midwife and health visitor to undertake professional self-monitoring and to strive for quality improvement in all aspects of the practice.

7.11 Whatever approach is adopted by NHS organisations, nurses, midwives and health visitors must contribute fully to the implementation of clinical governance to ensure standard setting,
monitoring, review and improvement encompasses the full spectrum of care and treatment, and does not focus narrowly on medical interventions and outcomes. In gauging the views of patients and users, NHS organisations should ask specifically about the quality of nursing, midwifery and health visiting and the relationships nurses, midwives and health visitors establish with patients and clients. This should provide an important source of feedback to teams and individuals.

7.12 National standards and effective practice need to be underpinned by a robust nursing, midwifery and health visiting evidence base. This requires investment in research and development, and in research and development expertise. We are committed to developing the research base, and to the development of a cadre of nursing, midwifery and health visiting researchers. This will be linked to our proposals for a new approach to career paths. Our plans to establish nurse, midwife and health visitor consultant posts will create new career opportunities enabling easier movement between posts in practice, education and research. We will:

- develop a strategy to influence the research and development agenda, to strengthen the capacity to undertake nursing, midwifery and health visiting research, and to use research to support nursing, midwifery and health visiting practice.

7.13 We will apply rigorous and systematic assessment to evidence that could inform nursing, midwifery and health visiting practice, and we will ensure it is properly disseminated, increasingly via the NHSNet and National Electronic Library for Health. But nurses, midwives and health visitors need to be able to seek out and apply this evidence. As part of their clinical governance development plans, and investment in continuing professional development, NHS organisations need to improve the capability of nurses, midwives and health visitors to appraise and apply research findings to their practice.
Evidence suggests that nurses, midwives and health visitors can make a significant contribution in the fight against Coronary Heart Disease through:

- nurse-led blood pressure clinics to identify and help manage hypo/hypertension and medication compliance;
- smoking cessation clinics using national smoking cessation guidelines;
- ‘healthy lifestyle’ clinics in collaboration with other health professionals to address factors such as diet, nutrition and exercise;
- cholesterol clinics to assist in risk identification and management;
- care for patients with congestive cardiac failure under ‘home-based’ initiatives;
- nurse-led chest pain clinics or risk factor screening and reduction clinics;
- the co-ordination and delivery of cardiac rehabilitation programmes in conjunction with other health care professionals.

**7.14** Together these measures will help strengthen evidence-based nursing, midwifery and health visiting practice, improve effectiveness and quality and minimise variations in standards of care.
Strengthening leadership

Key points:

- The Government’s modernisation programme means that more nurses, midwives and health visitors need better leadership skills.

- Work to equip them with these skills will be part of the wider programme to boost leadership and management across the NHS.

- A new career framework and introduction of nurse, midwife and health visitor consultants will provide a stronger focus for clinical leadership.

- Greater emphasis is needed on leadership development for Sisters and Charge Nurses.

8.1 Our programme of modernisation presents a challenging leadership agenda. We need visionary leadership to help build modern, dependable services and to inspire and sustain the commitment of nurses, midwives and health visitors during a period of significant change. Strong nursing, midwifery and health visiting leadership is needed at every level. It is needed to drive forward interagency and multidisciplinary team working, to improve quality and practice through clinical governance, to lead public health initiatives, to plan and commission services locally through Primary Care Groups and Trusts, and to provide effective management of clinical services and corporate functions.

8.2 We need to develop the leadership skills of more nurses, midwives and health visitors to meet this challenge. And we need to improve the preparation they receive so they can develop the competencies needed in a modern service. Our plans to improve health and healthcare call for a particular style of leadership. We need nurse, midwife and health visitor leaders who can establish direction and purpose, inspire, motivate and empower teams around common goals and produce real improvements in clinical practice, quality and services. We need leaders who are motivated, self aware,
socially skilled, and able to work together with others across professional and organisational boundaries.

Aspiring leaders need to be identified, supported and developed. Senior colleagues have an obligation to spot and nurture talent, to encourage and develop leadership qualities and skills and to create a professional and organisational climate that enables the next generation of leaders to challenge orthodoxy, to take risks and to learn from experience.

8.3 We are committed to boost NHS leadership and management across the board. All the work we will do to equip nurses, midwives and health visitors to lead different aspects of the modernisation programme will fit into our wider programme to strengthen clinical leadership at all levels and across all parts of the NHS, to boost public health capacity, support NHS Boards, to improve career and succession planning and to link this to our drive to spread good practice through the NHS ‘Learning Network’. We will:

- publish our plans to show how nurses, midwives and health visitors will have access to the wider programme to strengthen leadership and management across the NHS.

8.4 The introduction of nurse, midwife and health visitor consultants and the new career framework we have proposed supports the development of professional expertise and leadership skills. It will help increase career moves between practice, education and research, enabling potential leaders to acquire a broader range of competencies. Introduction of nurse, midwife and health visitor consultant posts will not only provide new opportunities for expert practitioners who choose to remain in practice to do so, but also provide a stronger focus for clinical leadership, helping to improve quality and shape services to make them more responsive.

8.5 But in many services the main task of clinical leadership will continue to rest with Sisters and Charge Nurses and their equivalents in both hospital and community settings. Leadership capacity and capability needs to be strengthened here too. Sisters, Charge Nurses and other team leaders have a pivotal role in NHS organisations. Their leadership is critical to the quality of care, treatment and outcomes, to staff morale and to the learning climate and opportunities available to students and others. They are
sometimes undervalued and do not always attract the recognition they deserve. Yet they are the backbone of the NHS and the hub of the wider clinical team.

8.6 Poor clinical leadership leads to poor standards of care. This is unacceptable and will be highlighted more readily by the new arrangements for clinical governance. Our concern to prevent lapses in the quality of the fundamental and essential aspects of nursing, midwifery and health visiting care and support, focuses on the implementation of clinical governance. This can happen only if there is effective clinical leadership. Clinical leadership programmes, such as the scheme run by the Royal College of Nursing, have shown how development programmes for clinical leaders involving action learning can have very positive results. Similarly UNISON is working with a number of NHS organisations to develop staff involvement and leadership. Programmes such as these need to become the norm rather than the exception.

8.7 Nurses, midwives and health visitors have made a significant contribution to corporate and strategic management too. This needs to continue. Opportunities to develop generic management skills and to enter corporate and strategic roles must be maintained to ensure that decision-making in the NHS is properly informed by nursing, midwifery and health visiting knowledge. A special focus is needed to support and develop nursing, midwifery and health visiting leadership in Primary Care Groups and Trusts to secure an effective contribution to planning and commissioning services.

8.8 Our plan to provide a lead from the centre needs to be matched by local commitment. Local audit establishing baseline assessments to implement clinical governance and the information from personal development plans, will provide NHS organisations with the information needed to help decide where investment in leadership and continuing professional development should be made. NHS organisations should have a clear understanding of where weaknesses in leadership capacity and capability present a risk to clinical standards. The best will have identified measures to close the gap. We expect NHS organisations to:

- review their current provision and investment in clinical leadership development to ensure nurses, midwives and health visitors have access to appropriate opportunities.
**NHS organisations should:**

- ensure all nurses, midwives and health visitors can benefit from a robust system of review and personal development planning;

- invest in continuing professional development to support clinical governance and in the development and support of clinical leaders;

- use clinical supervision and statutory midwifery supervision to help identify, support and develop nurse, midwife and health visitor leaders and potential leaders;

- establish effective succession planning and support and coach nurses, midwives and health visitors who aspire to leadership positions by providing opportunities for informal development such as mentoring, shadowing, job swaps, secondments and participation in learning sets;

- ensure nurses, midwives and health visitors from black and ethnic minority groups and part-time staff, who have traditionally been under-represented in career development activity, have equality of opportunity.
Modernising professional self-regulation

Key points:

• Public protection is central to the Government’s plans for modern, dependable health services

• The Government supports professional self-regulation but is committed to making it more open, responsive and accountable

• Subject to consultation and legislation, it will establish a new streamlined regulatory framework for nurses, midwives and health visitors

• The Government will commission a short review of the regulation of support workers

9.1 Raising standards and protecting the public is central to our plans for modern, dependable health services. We have made it clear that we will continue to look to individual health professionals to be responsible for the quality of their own clinical practice. But professional autonomy is both a privilege and a significant responsibility. It must be matched by a commitment to public accountability.

9.2 In a changing world where every nurse, midwife and health visitor is faced with new challenges and rising expectations, professional self-regulation is the cornerstone of public protection. It is at the core of clinical governance and provides the public with an assurance of minimum standards of professional competence and conduct. Professional self-regulation is central to the plans we have set out in Making a Difference.
We expect every nurse, midwife and health visitor to understand fully the obligations associated with professional registration and accountability. They should practice in accordance with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting Code of Professional Conduct and related guidance. We expect them to maintain and improve their professional knowledge and competence – at the very least to the minimum required during each registration cycle – and to acknowledge any limitations in knowledge or competence, undertaking new or expanded responsibilities in accordance with current guidance about the scope of professional practice.

9.3 In our plans for clinical governance we have made it clear that NHS organisations have a responsibility to ensure local structures support professional self-regulation. There must be systems in place to identify and remedy poor professional performance and to make speedy referrals to the regulatory body when this is necessary.

9.4 We want every nurse, midwife and health visitor to exercise professional autonomy and accountability in the interests of the patients and clients in their care and to do so in the context of a profession, entrusted by Parliament to regulate itself in the public interest. We have endorsed the principle that midwifery should continue to have a strong and independent voice in its own regulation and are determined that the distinctive contribution each profession makes within a joint regulatory framework be properly acknowledged.

9.5 But we have made it clear that we intend to strengthen professional self-regulation to ensure it is open, responsive and publicly accountable. Modern professional practice needs a modern regulatory framework. A framework that commands public confidence, is responsive to changes in education and practice and is valued by nurses, midwives and health visitors themselves.

9.6 We commissioned and published an independent review of the Nurses, Midwives and Health Visitors Act. The report identified weaknesses in the current Act and recommended new legislation. We have accepted this and plan to bring forward proposals for a new statutory regulatory framework.
Subject to consultation and legislation, we will:

- establish a new, smaller, UK-wide council to replace the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and the four National Boards to sharpen accountability and streamline regulation;
- lay a duty on the new council to treat the interests of patients and clients as paramount in carrying out its functions;
- ensure the new council collaborates with other stakeholders and consults appropriate interests;
- ensure there is a simplified register to make it easier for the public and employers to establish the status of registrants;
- require the new council to set standards for education leading to registration in terms of outcomes, to accredit institutions and quality assure courses, either directly or indirectly;
- give the new council additional powers so that it can deal more effectively with misconduct, poor performance and health issues.

9.7 To assist the transition from existing bodies to a new one, we will:

- support and work with a new Change Management Group, drawing membership from the five existing bodies;
- begin the process this year of preparing for new legislation including setting up a Reference Group of professional, employer, educational and lay interests to test out specific proposals and feedback from consultation on them.

9.8 We also accepted a recommendation to:

- establish a short review to explore the regulation of support workers.

The review will be commissioned this summer and report by the end of this year.

9.9 A new regulatory framework will provide better public protection and provide better support to nurses, midwives and health visitors to help them meet the challenge of change.
Working in new ways

Key points:

- The Government wants to extend the roles of nurses, midwives and health visitors to make better use of their knowledge and skills – including making it easier for them to prescribe

- It wants to modernise the roles of health visitors and school nurses to support the new health strategy and other policies

- It wants to see more nurse-led primary care services to improve accessibility and responsiveness

- The role of midwives needs to expand to include wider responsibilities for women’s health

- The introduction of new roles and role developments need to be carefully managed by NHS organisations

10.1 In chapter 1 we explained why a new vision and strategy is needed. In subsequent chapters we set out our plans to expand the workforce, strengthen education and training, build a more flexible career framework, improve the working lives of nurses, midwives and health visitors, enhance the quality of care, strengthen leadership and modernise professional self-regulation.

10.2 All these measures will help to unlock the potential nurses, midwives and health visitors have to offer the NHS. As we said in our White Paper – The new NHS: Modern Dependable – we are ‘particularly keen to extend the recent developments in the roles of nurses working in acute and community services’. Our ambitions are wider than this. We want to see health visitors adopt a new focus, we want to develop the role of school nurses in support of our public health strategy, and we want to make better use of the skills of midwives by introducing more flexibility into their roles. And we want NHS organisations to build on the developments which have already taken place, by reviewing teams and skill-mix to support role developments wherever they can benefit patients.
10.3 This chapter describes the way in which nurses, midwives and health visitors can improve services by developing their roles and the way they work. Supported by the strategies set out in previous chapters, our aim is to create the conditions which liberate and maximise the potential of nursing, midwifery and health visiting. But innovation needs to be balanced by a proper regard for patient and client safety and well-being. Wide variations in standards are unacceptable.

10.4 Ad-hoc developments which are poorly structured, inadequately supported, poorly managed or go unevaluated, have no place in a modern, dependable service. Opportunities for role development need to be carefully assessed and risks and benefits properly considered. Implementation needs to be rigorously managed, monitored and evaluated. At the end of the chapter, we balance our aspirations for innovation with guidance setting out the main considerations against which NHS organisations should test proposals for role development.

Modern roles in community and primary care

10.5 Nurses, midwives and health visitors working in primary and community care are developing their roles to help provide modern and dependable services. They act as health promoters, giving information to patients, assessing health risks and screening for early signs of treatable disease. They are public health workers, focusing on whole communities as well as individuals, fulfilling the public health functions of community profiling, health needs assessment, communicable disease control and community development. Health visitors and community nurses, working close to where people live in local communities, are acting as advocates for vulnerable groups and people who are socially excluded, making sure they have access to mainstream health services. We want to encourage, sustain and extend these developments.

Focusing on health

10.6 Our health strategy for England – Saving Lives: Our Healthier Nation – recognises the potential of all nurses, midwives and health visitors to play a major part in promoting health and preventing illness. They have contact with people at critical points in their lives which offer significant opportunities to promote health. During
pregnancy and acute illness people are often particularly receptive to advice and support about healthy lifestyle choices. With the onset of chronic illness there are important opportunities to help people manage and take control of their condition, minimising their dependence and maximising their mental and physical wellbeing. We expect nurses, midwives and health visitors to use these health promotion opportunities to the full.

10.7 Nurses, midwives and health visitors work in a variety of settings. They are exceptionally well placed to identify patterns and causes of ill health and to join with others to tackle them. Through their work with people who are vulnerable, those who are socially excluded and those at greatest risk of ill health, nurses, midwives and health visitors can help tackle health inequalities, targeting those in greatest need and they are often especially well placed to be able to identify and to help tackle the problem of domestic violence.

10.8 To take forward our policies we need to modernise the role of health visitors. We are encouraging all health visitors to develop a family-centred public health role, working with individuals, families and communities to improve health and to tackle health inequalities. Health visitors need to work in new ways, across traditional boundaries with other professionals and voluntary workers. They will work with Primary Care Groups, Trusts, other local agencies and with local communities to develop and deliver health improvement programmes and action set out in Saving Lives: Our Healthier Nation.

**A family-centred public health role for health visitors**

We expect health visitors to lead teams to include nurses, nursery nurses and other community workers that will:

- deliver child health programmes and work in partnership with families to develop and agree tailored health plans to address their parenting and health needs;

- run parenting groups and provide home visits to help improve support, advice and information to parents – and especially to vulnerable children and their families – supporting initiatives such as Sure Start;

- work through Primary Care Groups to identify the health needs of neighbourhoods and special groups such as the homeless, and agree local health plans;
• work with local communities to help them identify and tackle their own health needs, such as measures to combat the social isolation of elderly people or the development of local accident prevention schemes;

• provide health promotion programmes to target accidents, cancer, mental health, coronary heart disease and stroke.

10.9 We need to develop the public health role of the school nurse too, building on the opportunities their contact with children and young people provide. We want them to draw on their nursing knowledge and pastoral care experience to support policies such as the healthy schools initiative. We want them to help young people make healthy lifestyle choices, to reduce risk-taking behaviour and to focus on issues such as teenage parenthood. They will need to continue to work in teams in partnership with teachers, health visitors and others to provide an integrated programme of support and health promotion.

A public health role for school nurses

We expect school nurses to lead teams, to include nurses and other community and education workers, to:

• assess the health needs of children and school communities, agree individual and school health plans and deliver these through multidisciplinary partnerships;

• play a key role in immunisation and vaccination programmes;

• contribute to personal health and social education and to citizenship training,

• work with parents to promote positive parenting;

• offer support and counselling, promoting positive mental health in young people;

• advise and co-ordinate healthcare to children with medical needs.

10.10 We want occupational health nurses to play their part in our plans to improve health by adopting a broader public health focus in the workplace by, for example, working on programmes such as the back pain initiative. Their work needs to be integrated with the wider public health programme but we will look to them to take a lead in assessing and responding to health needs in the workplace.
10.11 Infection and communicable disease control is an essential part of our plans to protect the public’s health. We need to develop the role of infection control nurses, particularly in primary and community care settings.

10.12 To support these developments, we will:

- implement a programme to develop the public health aspects of all nursing, midwifery and health visiting practice but with a special focus on the roles of health visitors, school nurses, infection control nurses and occupational health nurses as public health practitioners.

10.13 We will establish a national forum for stakeholders to help develop and take forward a strategic development programme for public health nursing, midwifery and health visiting. This will be supported through our Innovation Fund. This is already funding projects in regions to help health visitors and school nurses develop the skills to adopt community development approaches, provide innovative programmes of parenting support, child health and family relationships, and to identify health needs at neighbourhood and Primary Care Group level.

Faster access, better services

10.14 Nurses are taking a leading role in providing the public with fast and convenient access to NHS services. NHS Direct – the nurse-led telephone helpline – provides prompt access to professional advice and reassurance, 24 hours a day, 365 days a year. By the end of 2000, the service will cover the whole of England. Building on these successes, we have plans to establish twenty NHS Primary Care Walk-in Centres by April 2000. Nurse-led services will provide health information, self-help advice and minor treatments. They will be open from early morning to late evening, and at weekends, to suit modern lifestyles.

10.15 District nurses’ roles are now central to the capacity of individuals to remain in their own homes, receiving appropriate packages of nursing care and treatment, through acute, chronic and terminal illness. They have a pivotal role as patient assessors, care co-ordinators and team leaders. In addition to long-term care, working with specialist nurses and others, district nurses are...
providing rapid response teams, enabling individuals with acute health crises to avoid hospital admission by providing intensive support for a limited period. Increasing the work of district nursing teams are supported by specialist nurses – such as those focusing on diabetes, respiratory disease or palliative care – who provide outreach services from hospitals or who are integrated with a number of community teams across a patch.

10.16 Practice nurses have built a unique professional role, providing a surgery-based health promotion, screening, disease prevention and treatment role. Their long-term relationships with individuals and families registered with the GP practice enable them to provide holistic, long-term care and support to people of all generations. It can also give them a privileged view of family life, enabling them to help identify where domestic violence may be occurring.

10.17 But a recent Audit Commission report – First Assessment: A review of district nursing services in England and Wales – highlights deficiencies in current provision as district nursing services try to cope with increasing demand. We believe there is scope to review the interface between district and practice nursing in the context of wider considerations about the potential of integrated and self-managed teams. The recent move to greater common core training for community health care nurses needs to be used to maximise flexibility within community nursing teams.

Prescribing

10.18 District nurses and health visitors, and practice nurses with a district nursing or health visiting qualification, have moved into new roles as nurse prescribers. By extending nurse prescribing nationally, we plan to train over 23,500 nurses and health visitors by 2001. They will be able to prescribe from the Nurses’ Prescribing Formulary, improving patient care and making better use of their own time and that of General Practitioners. This important development provides nurses with an excellent opportunity to develop new skills and to extend their roles in primary health care teams.

10.19 We will shortly be amending regulations to facilitate the development of group protocols, creating the potential for nurses, midwives and health visitors to administer a range of medicines without direct referral to a doctor. The establishment of Primary
Care Groups is likely to provide an opportunity to develop group protocols within a framework of clinical governance.

10.20 We have received nearly 200 detailed responses to our recent consultation on the Review of Prescribing, Supply and Administration of Medicines (the Crown Review). This will provide the basis for further developments.

Planning local services

10.21 Changes to primary care organisation, including the setting up of Primary Care Groups (PCGs), have brought new ways of working for community nurses and health visitors. Community nurses, midwives and health visitors have taken up new roles as planners and commissioners of care, filling nearly 1000 places on the boards of Primary Care Groups. They are working collaboratively at PCG level, through project groups and nurses forums, informing and influencing the PCG Board on service issues. Nurse members of PCG Boards have set up new systems for sharing information with colleagues across the PCG area, and for identifying and sharing good practice. Some nurses are taking the lead for clinical governance within their PCG, developing programmes of multidisciplinary audit, education and quality activity.

10.22 We want community nurses and midwives to take up places on both the Executive and Board of the new Primary Care Trusts in future, helping to improve the health of the local population, develop community services and commission secondary health services. In both PCGs and PCTs, they will work in partnership with local authority social services departments, with health authorities and with lay people, to develop and deliver local Health Improvement Programmes.

10.23 At individual primary health care team level, nurses and health visitors are increasingly working in integrated nursing teams. These teams bring together Trust and GP practice employed nurses to meet the needs of their local population. They allow team members to pool their skills, knowledge and abilities. Self-managing integrated teams also have authority for their objective setting and financial control. Working in these teams, with defined common objectives, enables members to gain a greater understanding of each other’s roles and expertise, reduce duplication, and make more appropriate use of specialist skills.

Bradford Community Trust has developed self-managed teams over several years following a positive reception by local nurses and GPs to initial piloting. There are now 40 self-managed teams comprising health visitors, district nurses and practice nurses. The teams – which select their own leader – have authority to plan and manage their work, devolved budgetary control, and responsibility for training, recruitment and performance review. They have reported improvements in referral and discharge processes, health needs assessment and caseload profiling, matching resources to workload and in shared care. They exercise a degree of flexibility in role boundaries and have greater scope to cover absences. The success of the self-managed teams has resulted from strong but enabling professional leadership and a clear understanding and acceptance about personal accountability. Effective systems of clinical supervision, peer review and opportunities to network and develop practice have also been crucial.
Community nurses and health visitors are also piloting new ways of working to deliver personal medical services (PMS) to people, particularly in deprived areas, or to vulnerable groups. They are leading PMS projects as practice partners with GPs, by running their own practices and employing GPs, or providing services to homeless people.

We want NHS organisations to support nurses, midwives and health visitors in primary and community care to build on these new roles and new ways of working, by:

- enabling nurses, midwives and health visitors to harness their collective representation at PCG or PCT level, so that their knowledge and skills and the information they have about the local community, can be used to influence decisions about the development of services at local level to benefit the local population;

- helping them to develop and pool skills through integrated team working to make a more flexible and responsive set of skills available to practice populations and local communities, while maintaining the defined professional expertise associated with the traditional roles the public have come to expect;

- developing a strong multi-professional community within each PCG or PCT which links individual teams with the organisation as a whole, so that coherent programmes of professional development, quality improvement and innovation can flourish.

Expanding the role of midwives

Midwives make an enormous contribution to the health of women and their babies and have pioneered the sharing of care responsibility with clients. But we need to make better use of midwifery skills. In pregnancy the midwifery role is already well defined but there is scope for midwives to apply their knowledge and skills more widely. In the longer term, this could include working with women to provide care and advice on all aspects of their health. We will:

- work with women, midwives and other professions to explore the opportunities for an expanded role for midwives which makes better use of their knowledge and skills.
10.27 More immediately, we want midwives to play a bigger role in our public health strategy. For example, working in partnership with school nurses and health visitors, they need to be more involved in helping to ensure young people are well informed about healthy lifestyle choices. Midwives are especially well placed to contribute on issues including contraception, sexual health, relationships and the responsibilities associated with pregnancy and childbirth.

10.28 Building on the excellent partnerships they establish with women in their care, midwives are well placed to play a bigger role in health promotion. They can help women to make informed choices by educating about diet, exercise, smoking and obesity that extend well beyond the immediate concerns associated with maternal and child health during pregnancy. They can help make services more responsive by providing antenatal classes and parenting groups at weekends and in the evenings and in places more accessible to those attending. And there is scope for midwives to help tackle inequalities by targeting vulnerable groups and those who do not traditionally use services.

10.29 Their close relationship with women during pregnancy and birth provides a powerful opportunity for midwives to educate about breast and cervical screening, and to prepare women for informed and healthy lives after the birth of their child. There is scope for midwives to extend their contact with women after birth to use their relationship and knowledge of the individual to improve the detection and referral of those mothers suffering from post-natal depression. ‘Active debriefing’ during the postnatal period can benefit not only the immediate health of the woman following childbirth but also their longer term psychological well-being. Women who have received debriefing as part of their postnatal care report that they feel better prepared to deal with the physical and psychological aspects of this significant life change.

10.30 Continuity of care in the postnatal period is important, especially so for first time mothers, for those who are breastfeeding and for those who are young or vulnerable. Too many women give up breastfeeding at or around the time care is transferred from one health professional to another.

10.31 As health visitors take on wider responsibilities, there is scope for midwives to extend their contact with women after birth, not only

In Bristol midwives are working with the Drug Service and with Community Psychiatric Nurses to provide an integrated service to pregnant substance abusers who might not otherwise have access to antenatal care. There is an emphasis on continuing support during the postnatal period with community midwives working hand in hand with the CPN. In London midwives have devised a parentcraft programme for women whose first language is not English which makes extensive use of appropriate visual aids. The programme has seen a significant rise in the number of women from black and ethnic minority communities who access parenting education.

In Winchester midwives have responded to the needs of women asking to discuss their birth experiences. Women are given the opportunity to see a midwife and talk through the experience at any time after the birth of their baby. The scheme is believed to help reduce the number of women who have a prolonged period of depression post delivery and is widely welcomed by women locally.
to provide ‘debriefing’, but also to undertake a wider physical, psychological and social assessment. By working closely with General Practitioners, and following training, midwives could expand their responsibilities to include the postnatal examination, provide continuing family planning advice and identify psychological and social problems such as relationship problems, depression and domestic violence, referring on as necessary. There are also opportunities for midwives to work more closely with health visitors and family planning nurses to help support and promote effective parenting and to provide well-women clinics. NHS organisations and primary care teams should:

- explore opportunities to make the best use of the knowledge and skills of the whole team and to expand the role of midwives where this provides more responsive care and services.

10.32 To help review opportunities to expand the role of midwives, to make better use of their knowledge and skills and to spearhead midwifery developments, NHS organisations should:

- consider opportunities to create midwife consultant posts, enabling expert, experienced midwives to remain in practice and to provide the strong professional leadership needed to reshape services to women.

Secondary care

10.33 In secondary care too, roles are changing and developing. Nurses are using additional knowledge and skills to enhance their contribution to the multidisciplinary team to provide better treatment and care to patients. They are looking afresh at the patient journey and designing care pathways to ensure patients progress smoothly through the whole spectrum of care. They are developing protocols with medical and other colleagues to enable them to exercise their professional judgement more fully and to make better use of their knowledge and skills to benefit patients in their care. And they are developing specialist skills to make full use of modern technology in areas such as cardiology, in neonatal and adult intensive care, in renal nursing, endoscopy clinics, in cancer and palliative care and in many other areas. Much of this requires further specialist training, often of a highly technical and specialist nature.
They have been active in helping develop care pathways to provide real benefits to patients, foster effective multidisciplinary team working, sharpen accountability and promote evidence-based practice and effective risk management. Nurse-led intermediate care is another example of the way in which nurses are improving services for patients and providing cost-effective solutions.

Intermediate care provides a means of relieving pressure on acute services and providing a more appropriate environment for recovery and rehabilitation. Investing responsibility for determining patient suitability and readiness for discharge with nurses helps provide a more responsive service and makes more appropriate use of resources and skills.

Nurses are also taking the lead in tackling growing problems such as hospital acquired infection. By taking the initiative and drawing on expert knowledge, they can make a real difference to the way in which services are co-ordinated to improve outcomes.

Innovative practice is not confined to acute hospital care. Working with learning disability clients and in partnership with other professionals, nurses have shown how clients who would otherwise fail to benefit from the services available to other members of the community can receive better care and support, enabling them to participate in decisions about their health and lifestyle.

The focus of mental health nursing has changed too. People admitted to hospital are more acutely ill and the number of people with severe and enduring mental illness needing care and support in the community has increased. Patients with mental health problems often present themselves in accident and emergency departments. Nurses have shown what a difference it can make to be able to call on expert psychiatric help.

In the community mental health nurses are providing care and treatment for patients with complex problems. They are working in partnership with other health professionals ensuring some of the most vulnerable and socially excluded people in society are able to access services. They are leading specialist substance misuse services and assertive outreach teams, they are engaging service users in decisions about care and services and are increasingly acting as an

In a District General Hospital in Wiltshire the Infection Control Nurse has established an infection control link nurse network, recruiting 65 link nurses from acute hospitals and the community. Infection control knowledge, compliance with policies by health care workers and within the wider care environment has been assessed through a quality and audit framework. It has clearly demonstrated quality improvements including lower rates of hospital acquired infection.

In London it was found that few people with learning disabilities were using specialist family planning services but were approaching community learning disability nurses. A domiciliary service has been established which links the learning disability nurse with family planning nurses and a family planning doctor. A learning disability nurse now visits prospective clients at home and uses specially designed visual packages and models to explain issues such as cervical smears, breast examination and contraception. Of 125 people with learning disability receiving the service, only 3 were previously known to the family planning service.
expert resource, supporting and advising primary care teams to help
them support people with mild to moderate mental illness.

10.40 In hospitals mental health nurses are caring for more acutely ill
patients. They are providing care for people with challenging
behaviours and those who present a significant suicide risk. Daily
they balance the challenge of maintaining safety and minimising
risk with evidence-based therapeutic interventions to promote
recovery and to maximise social functioning. The demanding nature
of acute psychiatric care and community mental health services
requires skilled and tenacious clinical leadership. Our proposals to
establish a more systematic approach to leadership development
are vitally important in this field.

Working with others

10.41 Effective care and treatment are the product of team effort.
Seamless services demand interagency working and collaboration.
Subject to proper regard for public protection, there is no place
for rigid demarcation of role boundaries in a modern service.
As services develop, local action is needed to help multidisciplinary
and interagency teams work effectively. The challenge is as much
for colleagues in other disciplines as it is for nurses, midwives and
health visitors. But nurses, midwives and health visitors are well
placed to help foster team work with other health and social
care professionals.

10.42 Working closely with statutory and voluntary agencies, children’s
nurses are leading teams to provide flexible and responsive packages
of care to meet the physical, emotional, educational, social and
spiritual needs of children with life limiting conditions, and the
needs of their families and carers. Eight Diana, Princess of Wales
Community Children’s Nursing Teams have been established to
provide seamless care in the community as an alternative to hospital.

10.43 Greater attention needs to be focused on the design of teams and
on role boundaries, focusing on patient needs and the patient
journey. Developing support workers to function across traditional
boundaries in support of a number of health professions, and
structuring teams to provide greater flexibility can produce positive
benefits for patients and staff.
10.44 Teams need to speak a common language. Inter-disciplinary patient records spanning primary, secondary and social care boundaries can help support integrated, seamless care. Patient and client involvement further aids the process. Participation in goal setting has been shown to have a positive impact on outcomes. Patient held records – which have been successful in health visiting and midwifery – are one vehicle through which health professionals can work more collaboratively. Information for Health provides a platform to take this further with the development of electronic health and patient records.

10.45 Collaboration and partnership needs to extend to patients, their families and carers. Greater effort is needed to engage service users, not only in their own care and treatment but also in health care decision-making. Caring about Carers highlights the responsibility of the NHS to consider their needs as well as those of patients and clients. Nurses, midwives and health visitors have an important part to play in providing information and education to help carers, particularly with techniques such as moving and handling skills, medication management, and in supporting carers groups and opportunities for respite care. Nurses, midwives and health visitors have a strong tradition of working closely with patients and clients and are in a good position to advise and help colleagues to do the same.

Promoting new roles and new ways of working

10.46 All this points to the often untapped potential of nurses, midwives and health visitors. Developing roles and improving services go hand in hand. Using nursing, midwifery and health visiting expertise more effectively as part of multidisciplinary team development is good for patients. And it provides more satisfying and rewarding careers for nurses, midwives and health visitors.

10.47 We support and want to encourage these developments. We expect NHS organisations to:

- support the role developments we have proposed and to continue to support, monitor and evaluate those now taking place;

- identify opportunities to establish nurse, midwife and health visitor consultant posts, following publication of detailed guidance;

In Birmingham a nurse employed by an NHS Trust who works within a social services department, was responsible for jointly commissioning and setting up an interagency rehabilitation service for older people. The service now provides very successful residential and outreach services on a multidisciplinary basis, tailored to the needs of the individual. Informal carers can take part in an innovative training scheme to gain a National Vocational Qualification in direct care. This has reduced the isolation felt by many carers and has improved their skills, self esteem and employment prospects.
look critically at skill mix and team structures to explore further opportunities to make better use of nursing, midwifery and health visiting knowledge and skills, wherever doing so can benefit patient care or improve quality or cost effectiveness.

10.48 The role developments we are proposing need to be carefully managed and properly supported. It is essential that NHS organisations give adequate attention to managing the process of change.

New roles, new ways of working
The development of new and expanded nursing, midwifery and health visiting roles needs to be a managed process. NHS organisations should ensure where they occur:

- the development is based on a thorough needs assessment and consistent with Government policy, and is designed to benefit patients and clients;
- the purpose and responsibilities can be clearly specified and the role invested with professional and organisational autonomy and authority which matches the purpose and expectations;
- the professional competencies and additional knowledge and skills can be identified and appropriate education, training, competence assessment, continuing support and supervision put in place;
- an assessment of risks and professional and legal liabilities is made and appropriate indemnification arranged;
- new or additional job titles properly reflect the role, experience, qualifications and professional status of the postholder so that patients and colleagues can be in no doubt that the individual is a registered nurses, midwife or health visitor;
- the role can be clearly located in the wider health care team, complementing and working collaboratively with others;
- any substitution for medical, technical or other roles does not obscure professional accountability for the fundamental nursing, midwifery and health visiting function;
• there are arrangements to monitor the contribution made, and to make adjustments to minimise risks and maximise benefits;
• the postholder can be properly supported through clinical supervision, leadership development and continuing professional development.

10.49 In the absence of a common nomenclature there has been a proliferation of titles that do not always properly reflect the work being undertaken, the professional background of the person doing it or the level and type of education and training which has been undertaken. In some instances this has confused patients, employers and nurses, midwives and health visitors themselves. Standardisation will require the collaboration of many stakeholders. We will:

• ask the Partners Council (that we proposed in chapter 4) to explore and to make recommendations about the potential for standardisation.
Key points:

- Action needs to be taken at national level, within NHS organisations and by individuals

- A number of approaches will be adopted to drive implementation and to monitor progress

- Periodic reports on progress and achievements will be published

11.1 Strengthening the nursing, midwifery and health visiting contribution demands concerted action at national level, locally within NHS organisations and by individual practitioners. We have set out a significant development agenda. An agenda designed to prepare nurses, midwives and health visitors to meet the challenge of change.

11.2 The action highlighted in the text serves as signposts for planning, and as milestones against which to monitor progress. National action will proceed against agreed timetables. Local action should be embedded in the wider programme of capacity and capability building taking place across the NHS.

11.3 A number of mechanisms will be used to drive implementation and to track progress:

- national action will be taken forward as set out in the preceding chapters and progress publicised in further guidance or announcements;

- a programme of regional and local conferences and workshops will follow elaborating and exploring key themes and issues;

- we expect NHS organisations to audit current practice against the points highlighted in the preceding chapters and to embed action in wider local development plans;
• the NHS ‘Learning Zone’ will be used to spread best practice and a Department of Health nursing, midwifery and health visiting web-site established to enable all those engaged in taking forward Making a Difference to share their experience and to exchange information;

• much of the action proposed will be monitored as part of the wider policy implementation programme, for example through the development of local clinical governance arrangements, the reviews undertaken by the Commission for Health Improvement, the performance management of National Service Framework standards, and achievement of targets such as those set out in Working Together;

• Regional Nurse Directors will play a special role in supporting and facilitating implementation by working through established networks of nurse leaders in Health Authorities, Trusts and in Primary Care Groups and Trusts, and monitoring progress in NHS organisations using existing performance management arrangements;

• progress on action for individual practitioners will draw on the professional requirements for continuing professional development linked to periodic re-registration. This will be supported by personal development planning within NHS organisations to underpin training and development plans and clinical governance;

• we will publish periodic reports highlighting progress and achievement and to publicise best practice;

• more generally, a stronger nursing, midwifery and health visiting contribution will help improve overall performance and outcomes, measured through the NHS Performance Assessment Framework.
Conclusion

11.4 We believe nurses, midwives and health visitors need to be supported to strengthen their contribution to our plans to improve health and healthcare. In this document we have set out our plans to:

- expand the workforce to put right the shortages created by the last Government;
- strengthen education and training to ensure nurses and midwives are properly prepared to contribute fully to a modern NHS;
- develop a modern career framework to provide more satisfying and rewarding careers;
- improve the working lives of all nurses, midwives and health visitors to enable them to balance their personal and family commitments outside with those of their careers;
- help nurses, midwives and health visitors to contribute to our plans to enhance quality;
- strengthen leadership within the professions and across the NHS;
- modernise professional self-regulation to make it more open, responsive and accountable;
- encourage and support new roles and new ways of working to release the untapped potential of nursing, midwifery and health visiting.

We have done so to enable nurses, midwives and health visitors to continue to make a difference.
Early milestones


Talks with NHS unions and employers about new national pay and conditions for NHS staff (1999/2000).

High level national campaign to improve working lives (1999/2000).


Explore the benefit of clinical practice benchmarking with the nursing, midwifery and health visiting professions (1999/2000).


Publish plans to show how nurses, midwives and health visitors will have access to programmes to strengthen leadership and management across the NHS (1999/2000).


Implement a programme to develop the public health aspects of nursing, midwifery and health visiting (1999/2000).

Work with women, midwives and others to explore opportunities for an expanded midwifery role (1999/2000).

Publish plans for the better management of NHS funded education in which the Department of Health will take on a more active and wider role (1999/2000).
A strategy to influence the research and development agenda, strengthen the capacity to undertake nursing, midwifery and health visiting research, and to use research to support practice (2000).

Personal Development Plans for nurses, midwives and health visitors (2000).


Partners Council to explore and make recommendations about potential for greater standardisation of roles and titles (2000/2001).


Up to 15,000 more nurses and 6,000 more training places (2002).
Delivering for nurses, midwives and health visitors

Some key action over the last two years

- Consultation on a new nursing, midwifery and health visiting strategy engaging many thousands of nurses, midwives, health visitors and others. Development and publication of Making a Difference.

- The largest real terms pay rise for nurses, midwives and health visitors in ten years.

- Increased investment in education with a commitment to fund an extra 6000 pre-registration student places over 3 years.

- A commitment to increase the qualified nursing, midwifery and health visiting workforce by up to 15,000 over 3 years.

- A national recruitment campaign this year resulting in over 53,000 responses to a helpline and over 1200 qualified nurses, midwives and health visitors returning to work in the National Health Service.

- Increased investment in return to practice courses enabling more nurses, midwives and health visitors to return to work after a break, including funds to support conversion courses for returning enrolled nurses.

- The development of cadet schemes and provision of salaries for health care assistants to widen entry into pre-registration education and training.

- Proposals for nurse, midwife and health visitor consultants to provide better career opportunities and to ensure patients and clients benefit from expert practitioners who might otherwise leave clinical practice.

- A new career framework linked to proposals to modernise pay and conditions for NHS staff.

- Introduction of NHS Direct – the nurse-led helpline – providing the public with direct access to nursing advice; and proposals to further improve access through nurse-led walk-in centres.
• Introduction of Diana, Princess of Wales Children’s Community Nursing Teams.
• Roll-out of nurse prescribing to 23,500 nurses and health visitors.
• Nurse, midwife or health visitor membership of Primary Care Group Boards.
• Commissioned an independent review of the Nurses, Midwives and Health Visitors Act and accepted recommendations for a new regulatory framework.
Associated publications


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