

Nursing: Towards 2015

Alternative Scenarios for Healthcare, Nursing and Nurse Education in the UK in 2015

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with assistance from Rebecca Stackhouse

Commissioned by the Nursing and Midwifery Council to inform the debate on the future of pre-registration nurse education. The contents do not necessarily represent the views of the Nursing and Midwifery Council

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Purpose

This paper was commissioned by the Nursing and Midwifery Council to inform the discussion on the options for change to the existing frameworks for the pre-registration education of nurses. The authors accept full responsibility for the content of this report, which does not necessarily represent the views of the Nursing and Midwifery Council.

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EXECUTIVE SUMMARY

This paper was commissioned by the Nursing and Midwifery Council in May 2007 to inform the discussion on the options for change to the existing frameworks for the pre-registration education of nurses. Chapters 1 to 3 provide a synthesis of the relevant drivers of change in UK healthcare delivery and the education of health professionals in the period to 2015. Three alternative 'scenarios' of healthcare at the end of that period are presented in Chapter 4, which show how these various drivers – in combination - might have developed. Chapter 5 considers healthcare in 2015 as a set of 'paradoxes'.

Health Policy and Healthcare

There will be modest overall population growth in the UK in the period to 2015, with a rapidly changing dependency ratio in the decade from 2020. In terms of the *demand* for healthcare, the nature and main causes of the burden of disease will change, but as yet there is little reason to be sanguine about the effectiveness of attempts to reduce obesity levels or health inequalities. A high priority will continue to be given to supporting the self-care of the growing numbers of people with long-term conditions. Demand for 'complementary approaches' to meeting health needs will remain high, as will patient demand for choice – on sources of advice, care packages and treatment, and access arrangements. On the *supply* side, there will be a growing – and increasingly diverse – role for the Third Sector, and reliance on the commercial sector to provide substantial elements of secondary care provision in England. Substantial benefits from much improved information technology will be apparent by 2015 – information for patients, about patients, on effectiveness and healthcare performance – and there will be examples of 'personalised' medicine derived from an understanding of the genetic basis of some common diseases. There will be growing use of telecare to support care at home, and new applications for biotechnology, bioengineering and robotics. Healthcare *policy* will continue to focus on measuring effectiveness, reducing variations in performance, improving safety and quality, improving productivity, designing more effective incentive systems, and engaging clinicians in all of this. There will be continuing turbulence in NHS managerial structures. Regulation (of services and the professions) will probably focus on quality and safety, reflecting the implications of devolution, and a sharing of the regulatory role between statutory regulators and employers. Substantial changes in the pattern of hospital services are likely, with further concentration of specialist services, and provision closer to home for the more generalist services. Greater coordination of effort between the NHS and Social Services will consume much attention.

Nursing

Within nursing itself, there are future potential workforce difficulties as a result of an ageing workforce, increased competition for nursing expertise from other countries, and financial difficulties that may affect commissioning of nurse

education. To maintain nursing numbers, it is important that recruitment and retention continues to have a high profile. Recent policy initiatives and emerging roles for nurses in response to healthcare demands dictate flexibility in the future nursing workforce. There will be an increase in specialist and advanced roles and a blurring of professional and sector boundaries. Care will follow the patient pathway, with an emphasis on community care and multidisciplinary team working. Nurses will have the opportunity to direct and lead care both within and outside the NHS and will be encouraged to take a more entrepreneurial stance. However, there is a lack of definition of roles and titles and a lack of clarity concerning career pathways and educational preparation for advanced and specialist roles. Recent developments related to the Knowledge and Skills Framework and a new White Paper on the 'Regulation of Health Professionals in the 21st Century' is attempting to address some of the issues surrounding the setting and maintenance of standards in the healthcare workforce.

Nurse Education

In nurse education, there is concern throughout the UK over the future recruitment and retention of nurses. Applications to pre-registration nurse education continue to increase, yet the rate of increase varies according to country, region and branch. The appropriateness of the four nursing branches which focus on collective groups rather than specialties has been questioned. Future health services may seek a more generic worker which is attractive in terms of meeting general health needs and offers a cost-effective approach. In contrast, there are strong concerns that generalist nursing would result in a deskilling of the workforce. Degree-level programmes could enhance the status of nursing in comparison to other health professions and provide nurses with skills needed that go beyond diploma level. Degree preparation may result in less diversity of applicants and difficulties of workforce retention. Policy recognises the importance of shared learning for health care professionals to develop integrated care services. Education will respond to the advances in global communication by providing a curriculum that acknowledges interdependent relations between countries, especially in Europe.

Scenarios for UK Nursing in 2015

Some of the possible inter-play between these various drivers is captured in the three alternative, contrasting scenarios for nursing in 2015. None of them are 'right' or 'wrong', but all are plausible, and they reveal different tensions and sets of dependencies.

Scenario A represents minimal change from the present state in which there are currently relatively few specialist nurses working at an advanced level, in a small number of specialist areas. The majority of nurses are working in more generalist roles supported by health care assistants. There is a fairly clear and generally understood distinction between nurses' roles and those of other healthcare professionals.

In **Scenario B** there is increased demand for specialist staff in a wide variety of roles. Many of these are filled by nurses, but an increasing number are now carried out by other healthcare professionals. There are also fewer generalist nurse posts. As a result, there are fewer trained nurses overall than in option A. The demand for health care assistants remains fairly constant.

In **Scenario C** nursing has responded to the increasing demands for specialisation by all registered nurses becoming specialists at a more advanced level. There are many more areas of specialisation (including advanced generalist nurses) and health care assistants bridge the gap in basic nursing care. However, the growth in the number of HCAs, and the loss of generalist nurse roles, has led to a differentiation in the levels of working of health care assistants.

The paper concludes with a set of '**paradoxes**' which try to capture some of the complexity of healthcare in 2015.

INTRODUCTION

Terms of reference

The team was commissioned by the Nursing and Midwifery Council in May 2007 to synthesise in a brief but authoritative form the evidence relating to relevant drivers of change to UK healthcare delivery and to the education of health professionals in the period to 2015. This was to include the development of appropriate scenarios to provide a degree of understanding of how these factors might inter-relate to form an evidence base on which options for change to the existing NMC frameworks for the pre-registration education of nurses, and in particular the nursing branch programmes, could be considered.

Who knows what the future will hold?

When he saw a fork in the road he took it

Wouldn't it be nice if we could predict the future? Well, not necessarily – it probably depends what the future holds. But fortune telling of one sort or another has proved to be immensely popular for millennia, and many people still regularly read their 'Stars' in newspapers and magazines. But is there any more to thinking about the future than mere entertainment – what's the point? After all, how can we know the 'unknowable'?

The short answer, of course, is that we cannot – by definition. But we nevertheless have to make decisions now which are capable of withstanding whatever might happen in the next few years. It is presumably better to make *choices* about the future, rather than unthinkingly move forward – to avoid the fate of the man who 'took the fork'. To do so, though, we have to make *assumptions*, and it's sensible at least to try to ensure that those assumptions are reasonable.

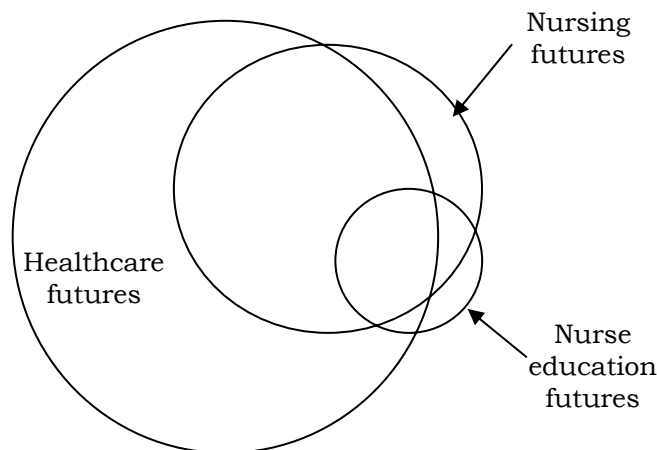
That is precisely what this document is for – to help the NMC (and all those interested in the issue) make reasonable assumptions about the future when making decisions about the future of pre-registration nurse education. This is not necessarily an easy task – we all tend to find it easier to concentrate on what we know (the present) rather than on what we can only surmise (the future); the danger is we end up reinventing the present. Major change of this sort take time to bring about; nurses then take three years to prepare for practice – so decisions made in 2007 will only begin to come into effect well into the next decade. It seems sensible therefore to make the best attempt we can to think through what sort of world these nurses will emerge into when they finally register.

Content

This document contains a summary of the key drivers likely to affect the future of nursing, followed by three 'Scenarios' set in 2015. Based on the enormous literature about the future, we present a synopsis of what we regard as the most relevant material, guided by three key questions:

- How is UK healthcare likely to change over the next 8-or so years?
- How is nursing in the UK likely to change over the same period?
and
- How is nurse education likely to change?

These questions are clearly inter-related:



The most powerful influences on the future of nurse education will be what happens to nursing, and the most powerful influences on nursing will be what happens to healthcare. All three will also be affected by a variety of other influences, some more-or-less immutable over this timescale (size of population, range of illnesses), others more susceptible to policy choices.

The scenarios are our way of drawing together all the various threads which emerge from the literature, and from which – to stretch the analogy – we have woven different tapestries of the future. Each scenario is a *possible* future – it *could* happen. There are, of course, an almost unlimited number of possible scenarios – and readers can (and should) construct their own. They highlight how some of the key dimensions should develop over the course of the next few years.

The scenarios are not intended to be definitive versions of the future. Rather, they are tools to be used by those trying to make decisions. Do different possible futures give us different opportunities and threats? Are our decisions robust, if different things happen? Are we really clear about what sort of future we want to create?

Literature

The aim was to review all of the key published and accessible 'grey' literature relating to these over-lapping domains. The possible implications of devolution in England, Scotland, Wales and Northern Ireland during this period was also considered.

The search began with a fairly broad global review of the literature bases CINAHL and MEDLINE, as well as searching Google. Various combinations of the following key words and terms were used: Future, Healthcare, Nursing, Nurse Education, Health Trends, Future Trends, Future Nursing Trends, Supply, Demand and Policy of Future Healthcare, Nature/ Delivery of Healthcare, Drivers of Change, Changes, Implications, Social Changes, Scenario, Training and Education, Healthcare Professionals, Healthcare projections, Healthcare predictions, Where is Healthcare going in the UK? In addition to a broad search of all Journals on CINAHL and MEDLINE the Journal of Advanced Nursing, the British Medical Journal, the Journal of Public Health, and the journals Health Trends and Futures, and were all individually searched for relevant articles. This was supplemented with any relevant UK government publications not identified in the search, such as policy documents and white papers. This was done by visiting the English Department of Health, Welsh Assembly Government, The Scottish Government and the Northern Ireland Assembly websites. Various nursing and medical organisation websites were then searched, including Nursing Midwifery Council, The Kings Fund, Royal College of Nursing, Nuffield Trust, British Medical Association, Nursing Standard, Nursing Times, The Health Foundation and some of the Medical Royal Colleges (i.e. General Practitioners, Physicians, Surgeons, Paediatrics and Child Health, Anaesthetists). The websites of other healthcare professions, namely Royal College of Midwives, British Dental Association, Chartered Society of Physiotherapy and British Association/College of Occupational Therapists, were also searched for relevant documents. Searches of Google were also made for relevant information and documents from European sources including the European Federation of Nurses Associations and the European Health Management Association (EHMA). International websites were also visited in the search, including: World Health Organisation, Organisation for Economic Co-operation and Development, The World Bank, The Commonwealth Fund and International Council of Nurses. Finally, all the references from the articles and documents that had been found were searched for any additional documents. Any relevant papers found this way were also obtained.

The documentary material which was used in compiling this paper is listed in three bibliographical sections at the end of the chapters to which they relate. In addition, reference is occasionally made in the text to specific sources where we draw on particular research evidence, or where the views expressed may be controversial.

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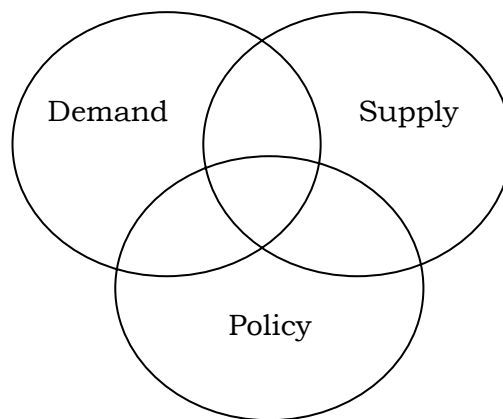
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CHAPTER 1

HEALTH POLICY AND HEALTHCARE: KEY DRIVERS

This chapter looks at the main aspects of healthcare and related policy which are likely to have a significant impact on UK nursing in the period to 2015. The key trends are described here, with their possible implications. Wherever possible, the consensus view is presented; where there is no consensus, it shows the range of likely outcomes.

There are clearly a large number of possible factors to be considered. To make this slightly more manageable, three inter-relating categories are discussed: the *Demand* for healthcare (demography, epidemiology, expectations), the *Supply* of healthcare (relating to the workforce, technologies), and healthcare *Policy* (formal government policies and strategies, local decision-making and implementation). Each is both an independent and dependent variable:



DEMAND

Population

As Table 1.1 shows, the overall population of the UK is projected to increase by about 7.2% over the period to 2016, as the result of greater life expectancy and migration, and the trend continues thereafter. Most of this increase occurs in England, where the population is projected to increase by 8% by 2016; the equivalent increases for Northern Ireland is 7%, 5% for Wales and 3% for Scotland. The proportion of people aged over 65 in the UK is projected to increase from 16% in 2006 to 22% by 2031.

Table 1.1 Mid year population projections (2004 base)

	2006	2011	2016	2021	2031
Total population:					
UK	60.6m	62.8m	65.0m	67.2m	71.1m
England	50.8m	52.7m	54.7m	56.8m	60.4m
Scotland	5.1m	5.2m	5.3m	5.3m	5.4m
Wales	3.0m	3.0m	3.1m	3.2m	3.3m
N Ireland	1.7m	1.8m	1.9m	1.8m	2.0m

Source: Office for National Statistics, 2007

All of this has some impact on the 'dependency ratio' – the proportion of children and people of retirement age compared with those of working age. In 2006 there were 3.3 people of working age for every person of state pensionable age; this is projected to fall to 2.9 by 2031, taking account of the change in state pension age. The major increase in older people occurs after 2020.

Health needs

Life expectancy at birth in the UK is comparable with that of the rest of the OECD. In 2005, UK citizens could expect 79 years of life from birth, compared with an OECD average of 78.6. However the UK lags behind European countries such as France, Italy and Spain. A similar picture is found in infant mortality, where the UK figure in 2005 was 5.1 deaths per 1000 live births, compared with an OECD average of 5.4. Again, however, the UK lags behind the Nordic countries and Japan. The increasing ability of the health service to support people born with profound disabilities, and to increase the life expectancy of others, will result in the provision of more support for disabled people overall.

Future projections suggest significant changes in the burden of disease. One recent study (Mathers and Loncar, 2006) generated projections for 2030. Table 1.2 shows its projections for high-income countries, according to its baseline scenario. Heart disease, cancers and cerebrovascular disease remain the biggest killers, although the balance between different cancers changes. In terms of disability, however, unipolar depressive disorders are easily the biggest single cause, accounting for almost 10% of the total, with two other factors often related to mental illness (dementias and alcohol use) in the top four.

Table 1.2 Ten leading causes of death and DALY*, high income countries, 2030

Disease or Injury	Rank	% of total deaths	Rank	% of total DALYs
Ischaemic Heart disease	1	15.8	2	5.9
Cerebrovascular disease	2	9.0	6	4.5
Trachea, bronchus and lung cancer	3	5.1	8	3.0
Diabetes mellitus	4	4.8	5	4.5
COPD	5	4.1	10	2.5
Lower respiratory infections	6	3.6	-	-
Alzheimer's and other dementias	7	3.6	3	5.8
Colon and rectum cancers	8	3.3	-	-
Stomach cancer	9	1.9	-	-
Prostate cancer	10	1.8	-	-
Unipolar depressive disorders	-	-	1	9.8
Alcohol use disorders	-	-	4	4.7
Hearing loss, adult onset	-	-	7	4.1
Osteoarthritis	-	-	9	2.9

Source: Mathers and Loncar (2006) pp 2023 and 2027

* Disability adjusted life year

- Not in top 10

Other factors relevant to disease prevalence but more difficult to predict include the possible emergence or resurgence of infectious diseases, facilitated by greater long-distance travel, and also perhaps in the longer-term by the impact of climate change. Recent Home Office estimates suggest that up to 650,000 people in England and Wales could die in the event of a flu pandemic of either avian or 'ordinary' strains. Other unpredictable events such as war, terrorism and mass migration could also possibly be significant.

Health preservation

Derek Wanless and others have identified as a key factor in the sustainability of the NHS the extent to which people engage in preserving their own health. In simple terms, the ageing of the population, together with more 'unhealthy lifestyles', could create a burden of ill health in the UK which could not be met by affordable levels of health spending.

Current trends present a mixed picture. The proportion of adults who smoke each day has declined markedly across the industrialized world in the last two decades, and currently stands at 24% in the UK and in the OECD as a whole. The rate of progress has slowed since the 1980s, and the impact of recent legislative changes is not yet clear. But an indication of what can be achieved is given by the 'best' performers – fewer than 18% of adults report smoking daily in Australia, Canada, Portugal, Sweden and the USA.

The opposite trend can be seen in obesity figures. In the past 20 years, the rate of obesity has more than tripled in the UK to a current obesity rate among adults of 23%. This compares with similar levels in Australia and New Zealand, and 32% in the USA. There is a time lag of several years between rising obesity and increased health problems (such as diabetes and asthma), suggesting that the UK might expect to see increases in these conditions in the period after 2015.

There has been a lot of public attention recently on particular public health challenges, such as smoking, binge drinking and the obesity 'time bomb'. As the English CMO pointed out recently in his annual report, such publicity can only be a 'good thing', putting pressure on individuals, communities, services, researchers and government to find solutions. It remains to be seen how sustained that interest will be, and more importantly, whether effective solutions are found.

Self care

Another aspect of health preservation is self-care – a term usually applied to people with long-term conditions, and the major challenge of helping them to preserve their health, mobility and general well-being, often in the context of a condition that is likely to deteriorate over time. Given that much of the future burden of disease will be borne by people with these conditions, the NHS, Social Services departments and others will need to pay more attention in the future to this issue. Particular challenges – which have not often yet been adequately addressed – include the need to recognise and meet the *totality* of people's needs (including, for example, employment, housing, income), and not just those addressed as 'health' or 'social care'; the need to ensure that the client/patient is genuinely able to exercise choice and control over what happens to them; and the need to support better the carers of people with long-term conditions.

Even within the somewhat narrower remit of healthcare, much remains to be done to ensure that everyone has timely access to the full range of high quality diagnostic, treatment and support services which modern healthcare can provide. This growing area will further reinforce shift in the balance of care from hospital to community and home; it will also offer many opportunities for all staff (including nurses) to develop specialisms and areas of advanced practice which effectively support self-care.

Complementary Healthcare

The Cochrane Collaboration defines complementary and alternative medicines as 'a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being.'

There is no doubt that complementary therapy is popular. Surveys have suggested that around one in three of the UK population have used complementary therapies at least once, and it is estimated that in any year, 11% of the adult population visit a complementary therapist for one of the six most common therapies. Perhaps 1 in 10 GPs is actively involved in complementary therapy, and a survey in 1989 (MORI, *The Times*, 13.11.89) showed that 74% of the public were in favour of complementary medicine being more widely available on the NHS. This popularity is unlikely to decline in the next eight years; indeed, as disposable income increases, as regulation develops, and as more complementary therapists are trained, the numbers using complementary therapies is likely to increase. It will be interesting to see whether their experience of complementary approaches will affect their expectations of the NHS.

Health inequalities

In addition to aiming for overall improvements in health and life expectancy, governments in all parts of the UK have pledged to reduce health inequalities. In England, for example, the target is to reduce inequalities (as measured by infant mortality and life expectancy) by 10% between 1997 and 2010. It is unlikely that this will be met. Despite progress in reducing child poverty, which should have a longer-term impact on inequalities, other indicators are heading in the wrong direction. For example, between 1997 and 2001/3 in England, the gap in life expectancy between the bottom quintile and the population as a whole had widened by 2% for males and 5% for females.

There has been much dispute between politicians of the left and right over the priority to be accorded to health inequalities, and it remains a priority mainly for left-of-centre parties. Thus the future emphasis will remain partly a function of general election results. But the problem of health inequalities remains intractable, and will not be solved by 2015.

Patient and carer expectations

The expectations of service held by patients and their carers are clearly an important element in shaping those services, and are often used to support one policy initiative or another. However, such expectations are very difficult to define let alone measure. Some measurable changes are partly a manifestation of expectations – the number of complaints or level of litigation, for example, or people's responses to surveys and focus groups – but most are also a function of other changes, such as in legal practice, or people's response to what the government or professionals encourage them to believe are their rights.

One obvious indicator of expectations is the extent and type of choice which people want in relation to the services they receive. There are different political perspectives on 'choice' within the UK, and there are negative views on choice inasmuch as it is linked with quasi-markets in the NHS. Nevertheless, some aspects of choice clearly do matter to patients and

carers, and research by the Picker Institute (Coulter, 2007) suggests a hierarchy of choices:

1. choice of clinician/source of advice
2. choice of care package (long term conditions)
3. choice of treatment (acute conditions)
4. choice of appointment time
5. choice of location

Various initiatives to encourage choice, to expect shorter waiting times, to tighten regulation, and for the recognition of the legitimacy of the carer as a service recipient, stimulate this trend, as probably do the availability of information, levels of expectation and broader emphasis on the rights of the 'consumer'. None of these factors is likely to abate in the future.

Summary

- Modest overall population growth, mainly in England
- Shifting dependency ratio after 2020
- Shifting burden of disease
- Continuing downward pressure on smoking, but little sign of progress on obesity
- High priority on supporting self-care in long-term conditions
- Continuing demand for complementary approaches
- Persistent health inequalities
- Growing demand for patient choice e.g. on sources of advice, care package and treatment, and appointment time

SUPPLY

Workforce recruitment and retention

In line with increases in health spending (see section on Policy), the numbers of health professionals in the UK has also been increasing. In 2005 there were 2.4 practicing physicians per 1000 population compared with 1.9 in 1998, but still below the OECD average of 3.0 and well behind the 3.4 of other European countries such as France, Germany and Sweden.

After a period of relative stability the number of nurses has also been increasing, but in this case the UK is above the OECD average. In 1998 there were 8.0 nurses per 1000 population, and 9.1 in 2005. This compares with an OECD average of 8.6 nurses per 1000 population in 2005.

In addition to the longer-term oscillations in the demand for, and availability of healthcare professionals in the NHS – which will probably continue to bedevil workforce planning in the period to 2015 – the pressure to ensure that UK doctors' working weeks comply with the European working directive will force changes to the allocation of roles within medicine and between medicine and other professions, and will hasten a wider appraisal of the balance of care within the NHS (see below).

Voluntary (or Third) Sector

The term 'voluntary' sector is, of course, something of a misnomer – it is a major employer, and increasingly an essential component in public service provision. So, increasingly, the term 'third sector' is gaining currency across the political spectrum, especially among those in policy making circles who now put great store by its future capacity to address a wide variety of social problems and public service delivery challenges. This growing interest in the third sector stems partly from an awareness of what some would see as the inherent limitations of publicly-owned services – slow-moving, cautious, dominated by the professionals – and also a recognition that the third sector offers great scope to involve people in *solving their own* problems.

It is likely, therefore, that the Third Sector will by 2015 have assumed a greater role in:

- Acting as the 'recognised' advocates of vulnerable groups
- Strengthening communities, by developing and owning (with government financial support) physical infrastructure in disadvantaged communities and building a wide variety of different social networks
- Providing public services, as part of the desire in each UK country to encourage a diversity of supply (with or without market competition)
- Social Enterprise, which some now regard as a preferred model for achieving all of the three roles above.

The health sector in particular is likely to be affected by these trends, with more professional staff being employed in the sector. This is likely to include both 'health promotion', including varieties of community development, and also major service provision, especially in areas where the Third Sector's expertise is most distinctive (such as aspects of community care, mental health and learning difficulties, substance misuse). The already apparent tensions about this direction of travel will probably persist and even grow, however – the inevitable result of trying to forge partnerships between self-directed voluntarism and a state paymaster.

Commercial sector

The commercial sector has always had a major role to play in healthcare delivery, particularly in the supply of pharmaceuticals, medical equipment and buildings, and in providing many aspects of long-term care. One might also argue that most of primary healthcare has always been shaped by commercial incentives, and the complementary healthcare sector almost entirely so. Yet the issue of commercial healthcare remains controversial. The biggest change in recent years has been in the commercial sector starting to provide secondary healthcare, paid for by the NHS, and therefore employing growing numbers of professional staff. For many, this has been an undesirable development, to the extent that governments in Scotland, Wales and more recently Northern Ireland have all expressed their determination to ensure that commercially-provided healthcare does not expand significantly

within their jurisdictions. But in England, there seems little prospect of a retreat from this more mixed market approach.

The extent and nature of the future role of the commercial sector throughout the UK is likely to be affected by three main factors:

- the overall demand for healthcare of all sorts – which seems likely to continue to expand
- the extent to which people are prepared to pay for private healthcare themselves, which is itself a function of disposable income and the perceptions of the NHS. The former will probably increase, the latter are more unpredictable
- the ideology of the governments – which are likely to remain either agnostic or broadly supportive in England, but somewhat suspicious of the commercial sector in the rest of the UK.

Information and Information Technology

The importance of information – and the technologies which make it available, understandable and usable – is difficult to overstate. There will have been substantial investment in such technologies by 2015 – both from the NHS and from commercial suppliers outside the formal healthcare system. In terms of the future of healthcare, there are at least four types of impact of significance:

➤ *Information for patients*

More information is now available to human beings than ever before, and it is expanding rapidly every day. By 2015 most people in the UK will have broadband access to the internet, with all it offers in terms of information on health and healthcare. Much of this will not be 'quality controlled', although there will also be many 'reputable' web sites. The extent to which this will materially change people's behaviour is unknown, and will probably vary greatly between different categories of people. Greater availability of information – and especially the use of web-based 'intermediaries' able to gather and present information in response to specific queries – is likely to have paradoxical results. For instance, people may develop both a better understanding of health and disease, and also more misconceptions and confusion; people may be more challenging of healthcare professionals, and also more dependent upon them to resolve their confusion; they may be better able to use information to make choices (about what help to seek, where and from whom), but also more dependent upon a trusted third party to interpret and perhaps negotiate on their behalf.

➤ *Information about patients*

Information on individuals' physiology and genetic profile, as well as their clinical history, will almost certainly be more easily available both to healthcare professionals and individuals themselves by 2015. This has the potential to improve efficiency and treatment (especially in unscheduled care), and to facilitate patient choice of provider and intervention. Much will depend, though on who has access (for example, which healthcare professionals, social care providers and the voluntary sector) and how easily, and as always the quality and comprehensiveness of the data input will be crucial.

➤ *Information on what works*

Unjustified clinical practice variation has long been a cause of concern. Universal access to modern information and decision-support infrastructure has the potential to reduce such variation, not least when patients themselves and their supporters use such information to challenge the care they receive.

➤ *Information on what's happening*

Information and information systems derived from activity data are growing rapidly in completeness and sophistication, and their importance to providing good care is now generally accepted. Such developments are likely increasingly to drive efficiency and quality initiatives.

Genetics and personalised medicine

In its forward to the *Fit for Practice in the Genetics Era* report the NMC asserted that genetics had become an issue that nurses 'cannot observe from the sidelines' (Kirk, McDonald, Anstey, Longley 2003, p4). This applies to meeting the needs now of patients and their families with, or at risk of, a genetic condition, as well as to preparing to embrace the potential for genetics to 'revolutionise' healthcare. The great prospect is an era of personalised medicine, where an understanding of the genetic basis of common diseases results in the development of a new generation of more effective medicines, and personal genetic profiling to match medication with patient on a far less 'trial-and-error' basis than at present. Genetic profiling will also allow for more effective and personalised health preservation. But the 'potential' also includes new insight into existing conditions and more effective management means that patients with serious genetic conditions are surviving longer, and making reproductive decisions.

It is not clear what will be the net economic consequences of this trend. On the one hand, new drugs, targeted at small groups of patients, are likely to be expensive; on the other, better targeting and more effective interventions could reduce the burden of disease. Nevertheless, scientific and technological progress in healthcare has for many years driven costs at a faster rate than general inflation, and this will probably continue.

To date, the clinical benefits of the genetic-led scientific revolution have been small, reflecting both the complexity of the aetiology of common diseases, and the time required to apply the results of basic scientific breakthroughs in the human genome and to develop and trial new medicines. These clinical developments (including insights into existing conditions) *are* gradually emerging (for example in the use of cytochrome P450 profiling for treatment of some mental health conditions and to inform warfarin dosage), and the danger is that talk of a revolution (as an event that is yet to happen), and speculation on a future that may seem remote now, may lead to complacency in ensuring that the current nursing workforce has genetics in its everyday 'toolkit'. The argument that nurses need a basic level of genetics literacy now has already been made and endorsed by the NMC and by the Department of Health in its genetics White Paper (2003). For 2015, nurses will need to be

able to build on this basic literacy to interpret the literature and communicate this, along with complex risk information, to patients. They will also need to set the information into the context of the patient's wider environment. We do know that by 2015 we are still unlikely to be able to alter much of the human genome – the environment may be a more productive target.

Telecare

There is a substantial and rapidly growing range of equipment designed to provide remote care. It ranges from the familiar community alarms which can summon assistance when needed, to sophisticated monitoring and diagnostic technologies which allow for remote consultations, and for people with long-term conditions to maintain their independence. But the potential is great. It is estimated that 90% of older people want to live at home, yet half a million live in care homes. Department of Health research (Department of Health (2005) *Building Telecare in England* London: DoH) suggests that 35% of them could be helped to live at home or in sheltered housing through greater use of telecare. Telecare provision is set to expand by 2015, especially if NHS and Social Services cooperate in its provision for those clients for whom they share responsibility.

Biotechnology, bioengineering, robotics

The conjunction of engineering and biology has the potential to deliver major benefits in areas such as biomechanics, neuroengineering, biosensors and tissue engineering. Examples from this wide field could include intelligent monitoring devices to monitor blood vessels, implantable materials of various sorts, or bionic constructions to replace lost limbs. Each development individually often benefits small numbers of patients, but the cumulative impact on some of the most complex and debilitating conditions cared for by the NHS could be significant.

The combination of computerised technology and communications connectivity is making the use of robotics in healthcare a more practicable proposition. It offers at least three potential advantages. First, it can improve accuracy in surgical procedures, for example in urology and ophthalmology, where this is particularly at a premium. Second, in non-invasive techniques, robotics can improve care by, for example, reducing blood loss. Third, as an aspect of telecare, robotic technologies have the potential to improve access to highly specialised staff.

Summary

- Numbers of health professionals will vary in the short term, but will remain high
- Growing role for the Third Sector
- Continued reliance on the commercial sector for aspects of acute provision in England
- Early benefits of 'personalised' medicines, and growing demand for information on the implications of genetics
- Substantial investment in information technology for patients, about patients' care, on effectiveness and on healthcare performance
- Growing applications for telecare, especially in supporting people at home
- New applications for biotechnology, bioengineering and robotics

POLICY

Tax payer and electoral pressures: efficiency and performance

Total health spending in the UK – both in absolute terms and as percentage of Gross Domestic Product – is rising. Total health spending in the UK accounted for 8.3% of GDP in 2005, compared with an average of 9.0% across OECD countries. In terms of spending per capita on health, the UK matches the OECD average (\$2724 in 2005 adjusted for purchasing power parity, compared with an OECD average of \$2759). The share of health spending which comes from the public sector is much higher in the UK than the OECD average, and is also rising – increasing from 80% in 1998 to 87% in 2005 – reflecting the government’s commitment to increase public spending on health.

The total amount of state spending on health is largely a function of the strength of the economy and the balance of political ideology. Private spending is also influenced by disposable wealth, and by perceptions of the NHS. Each of these factors is difficult to predict, and this uncertainty is reflected in the scenarios later in this paper.

Health is often a high profile political issue, and clearly has some bearing on the outcome of elections. Voters are often taxpayers, but older voters also tend to be larger consumers of healthcare. The much-heralded emergence of grey power is not yet evident, but the growing numbers of older people, the shift in the dependency ratio (especially in the decade after 2020), and the greater propensity of older people to vote, give potential electoral significance to demographic change.

In general terms – although particular emphases may vary with political change – it is likely that efficiency and performance will stay at the top of the political agenda. In the context of the need to help people to preserve their own health more effectively, and to support people in the self-management of long term conditions, this is likely to lead in the period to 2015 to sustained effort in at least the following five key areas:

- Measuring what counts: health – most targets and performance indicators are still far too focused on process issues
- Reducing variations in performance and clinical practice – the many unexplained variations between good and bad is clear *prime facie* evidence of scope for improvement
- Improving productivity – additional resources in the NHS have not yet led to the sort of sustained productivity improvement which is necessary
- Designing effective incentive systems – different approaches have been explored in different parts of the UK (quasi markets, ‘command and control’, local empowerment, partnership and cooperation), and different lessons have been drawn, but the panacea remains elusive

- Engaging clinicians – the centrality of clinicians in improving efficiency and performance has been clear for many years, but few would yet claim that they are fully and effectively engaged in this agenda.

NHS Structures

It is likely that the NHS will see major organisational change in the next eight years – not since the 1960s has the service enjoyed a period of eight years without such change. Such change is now largely determined within the four countries, and there are discussions now in all four locations on the respective merits of different organisational models. There is a growing gap between the four nations in their views on the merits of ‘quasi-markets’, for example, which itself may lead to organisational change. There has also been a resurgence of interest recently in the model for the service as a whole, with Brian Edwards (2007) for example, discussing the merits of seven different models, ranging from an ‘NHS corporation’ to commissioning by local government.

Quality and safety

There is likely to be strong and sustained interest in the quality of healthcare and the safety of patients, and corresponding support for initiatives (by nurses and others) which address these issues. The precise foci of concern, of course, are notoriously changeable. MRSA and *clostridium difficile* are currently topical, and campaigns to encourage professionals to wash their hands – and patients to challenge them to do so – are receiving much attention. There is also attention on the infrastructure to improve safety and the role of the National Patient Safety Agency. The regulation of the professions also has a major part to play in this agenda.

Many of these specific current topics will no longer be relevant by 2015, but the general issue of quality and safety will probably be even more important for nurses and others, as the evidence of performance improves, as professionals are supported in addressing the issues, and as patients are repeatedly encouraged to report and compare their experiences, challenge bad practice and seek redress.

Regulation

The last ten years have seen the development of a wide variety of regulatory mechanisms focused on different aspects of healthcare delivery, and a settled pattern of regulation has not yet emerged. The complexity is multiplied by the variety of foci (healthcare, social services, all the professions), topics (different issues emerge as priorities depending upon what is attracting political attention), countries (some elements are ‘reserved’ to Westminster, but many are devolved) and the changes in the mechanisms themselves. There is also debate about the overall governance of the NHS, particularly the extent to which it should be operationally accountable to Ministers.

It is safe to predict, therefore, that the precise pattern in 2015 will be different again from that in 2007. Certain principles and trends will probably still be operating, however:

➤ *Safety and quality of care*

Every regulatory regime justifies its existence in terms of safety and quality of care. This is one of the major shifts of recent years – professional self-protection, for example, is no longer an acceptable *raison d'être*.

➤ *Devolution*

Although the NMC's remit covers all four countries of the UK, the diverging models of service provision have spawned some different regulatory mechanisms (in, for example, the various Inspectorates); and even the 'reserved' regulation of healthcare professionals pays regards to the difference within the UK.

➤ *Shared responsibilities*

The focus on the key objectives of improving safety and quality of care and proportionality has encouraged a slightly broader consideration of the most appropriate means of achieving them. Two new approaches have emerged from this. One is to consider the potential contribution of all stakeholders and not just the statutory 'regulator' – employers, for example, have a major role to play in the 2007 professions' White Paper. The second is to take account of the patient's own role – for example, by ensuring that information relevant to regulation is in the public domain.

➤ *Proportionality*

Throughout the various changes to regulatory regime, everyone acknowledges the need for the arrangements to deal effectively with significant risks, without creating unnecessary burdens where risks are low. However, the burden of regulation is very difficult to quantify, which makes it difficult to ensure such proportionality.

➤ *More not less*

Kieran Walshe, in his study of regulatory regimes in the USA and UK, describes the 'regulatory ratchet' which 'appears to ensure that regulatory requirements are rarely relaxed or disestablished, and that each year regulation bites a little more tightly' (2003: 222). All healthcare systems appear to be committed to the importance of regulation as a key way of ensuring standards are maintained, although recent interest in 'earned freedom' from detailed regulation through proven good performance might lead to some mitigation of this approach

Evidence-based rationing

The NHS has always used rationing mechanisms to balance demand for, and the supply of healthcare. The most ubiquitous of these has been waiting times – for both primary and secondary care – but as such waits have been reduced, and as incentive systems have rewarded those in the NHS who

carry out more work, waiting times lose some of their utility as a rationing mechanism.

Not surprisingly, therefore, there has been a resurgence of interest lately in the notion of explicit rationing, and this probably will remain an important thread over the coming years. There are various possibilities – the NICE-type approach, for example, to accept or reject individual interventions according to a calculation of their comparative costs and benefits; or an approach which defines the purpose of the NHS and thereby excludes whole *categories* of intervention which don't fall within that purpose.

Both have their merits, and the NICE approach will probably survive for some time to come. But alone it will not have sufficient impact on the potential gap between supply and demand – hence the interest in the second approach, which has recently been backed by the BMA. But this approach has difficulties too. For example, the exclusions will be highly contentious, leading to methodological, legitimacy and other challenges – and many other countries which have tried 'menus' of entitlement have often allowed in the excluded items through the back door. Also, such an approach tends to say little about level or quality of service. Nevertheless, it is quite possible that some of the various UK governments, over the coming years, might seek to adopt elements of this approach, as NHS budgets come under pressure.

Future patterns of specialist and generalist healthcare

The UK has a smaller hospital sector – per capita, and as a proportion of the total healthcare system - than many other comparable countries. For example, in 2005 the number of acute care hospital beds in the UK was 3.1 per 1000 population compared with an OECD average of 3.9. In most OECD countries – including the UK – this figure is falling and will continue to fall, as average lengths of stay decrease and more surgical procedures are carried out on a day-care basis.

The UK also invests less in many aspects of high technology care. During the past decade, for example, there has been a rapid growth in the availability and use of diagnostic facilities such as CT and MRI scanning. There has also been some increase in the UK, but by 2005 far fewer CT and MRI scans were being performed in the UK than elsewhere – 5.4 MRIs per million population in the UK compared with an OECD average of 9.8, and 7.5 CTs per million compared with an OECD average of 20.6.

Against this background, policy on healthcare delivery models in each of the four UK countries is pursuing a set of fairly common objectives, driven by two main drivers: the need to concentrate specialist, low-volume services in a smaller number of locations; and the provision of more services (which have previously developed in DGHs) in community settings, or even in people's own homes. These drivers, in turn, are propelled by the secular growth of greater specialism within healthcare as a way of delivering ever better quality of care.

The net result is that Enoch Powell's early 1960s' blueprint of a district general hospital (and similar models outside England and Wales) providing almost all specialist care for its local population of about a quarter of a million people is now in need of major modification. Depending on local circumstances, the DGH will be pulled in two directions. Specialist services (e.g. paediatric surgery, major trauma, high risk obstetrics, cancer services) will be centralized in a regional hospital serving perhaps more than a million people. At the other end of the specialism spectrum, an increasing number of services no longer requiring a hospital base will be relocated to primary and community care settings, and sometimes to people's homes. These will include specialist support of various sorts for people with long term conditions, as well as a variety of diagnostic and assessment services for conditions which themselves do not require hospital-based care. Quite what will replace the DGH is not yet certain, but the uniform DGH 'blueprint' will have to evolve into many different models to suit local needs.

For the healthcare professions, this is already leading to a series of 'substitutions' – of location, and of role, as different levels of specialism and degree of advanced practice emerge to better reflect the new pattern of care.

Social care

So far, with the exception of Northern Ireland, health and social care have retained separate funding (and charging) mechanisms, lines of accountability, and even cultures – despite the fact that they share many clients in common, and often have difficulty establishing a rationale for their separate roles based on client needs. There have been various attempts in the rest of the UK to encourage greater cooperation between the NHS and local government, as the main provider of social care, such as pooled budgets and various joint appointments and processes, but often with only modest success. Persistent problems with delayed transfers of care, cumbersome joint assessment processes, and operational difficulties speak to the need to find a better solution to this problem, and few stakeholders are happy with the current arrangements.

There are now some discussions about formal merger of the NHS and Social Services, although this creates perhaps as many problems as it solves. It remains as one possible outcome by 2015. Another – perhaps more likely – is further pressure for, and experimentation in joint working of various sorts, in commissioning and service provision. This approach relies on extending the examples of success which have been achieved so far, and also on creating an incentive system which ensures that the issues receives the priority which its complexity obviously demands.

Ethical issues

It is perhaps unlikely that the moral compass of the UK will shift significantly over the next eight years, but change within healthcare might generate new ethical dilemmas, or give added impetus to existing ones. Three examples are often discussed – the improvements in survival chances of premature

babies, the demand for control over the timing and nature of death for people with terminal conditions, and the ethical, social and legal ramifications of genetic profiling.

Summary

- Common thrusts in policy: focus on measuring effectiveness; reducing variations in performance; improving productivity; designing effective incentive systems; engaging clinicians
- Continuing turbulence in NHS structures
- High profile for improving quality of care and safety
- Regulation: focus on quality and safety; reflecting devolution; sharing responsibilities with employers; aim for proportionality
- Continuing effort to improve evidence-based decisions on future provision of services
- Revision of pattern of hospital services: concentration of specialisms, and more care closer to home
- Continued effort to coordinate working between the NHS and Social Services
- New ethical challenges

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CHAPTER 2 NURSING: KEY DRIVERS

THE NURSING WORKFORCE

As of March 2006, there were 682,220 nurses and midwives on the NMC register compared to 644,024 in 2002, demonstrating an upward trend in the number of nurses, resulting from government policy of expansion in the NHS. Table 2.1 shows the breakdown by country of the UK, and table 2.2 the number of registrants on each part of the register. This growth followed a period of decline in the numbers of new nurses during the previous decade.

Table 2.1 Geographical breakdown of the NMC register as of March 2006.

Country	Number on register
England	532,016
Northern Ireland	22,833
Scotland	65,350
Wales	32,434
Non-UK address	29,366

Table 2.2 Numbers of nurses on the nursing part of the register in relation to field of practice as of March 2006

Branch	Total Numbers
<i>Adult</i>	<i>628,512</i>
<i>Mental Health</i>	<i>87,739</i>
<i>Children</i>	<i>40,264</i>
<i>Learning Disabilities</i>	<i>20,197</i>

Table 2.3 shows the age breakdown of the register indicating a gradually aging workforce with 63.34% over the age of 40 years and 29% over 50 years of age, which may have significant impact on the nursing workforce in the future.

Table 2.3: Age distribution of the NMC register for 2002-2006

Age range yr ending 31 March	2002	2003	2004	2005	2006
	%	%	%	%	%
<25yrs	2.24	2.10	2.02	1.94	1.87
25-29yrs	8.86	8.54	8.44	8.29	8.04
30-39yrs	30.63	29.37	28.30	27.35	26.72
40-49yrs	32.32	33.26	33.94	34.42	34.52
50-54yrs	11.46	11.46	11.62	11.91	14.42
55yrs +	14.50	15.27	15.68	16.09	16.40

Migrations in and out: One 'quick fix' method of managing workforce demand is to bring in nurses from other countries. There were increasing numbers of admissions to the register from India and the Philippines from 2002 onwards which were beginning to decline in 2005/6 (3,551 from India and 1,541 from the Philippines in 2005/6). There were 764 admissions from the EU accession countries in 2005/6, the majority from Poland and this is likely to increase in the future. However, migration of nurses into the country was restricted in 2006 by removing bands 5 and 6 from the Home Office 'shortage occupation' list. It is more difficult to assess the extent of migrations out as these can only be estimated from verification checks made by regulators outside the UK for nurses and midwives on the NMC register, of which there were 7,772 in 2005/6. The majority of these were for Australia, USA, New Zealand, and the Republic of Ireland. These may not have all continued on to take up posts outside the UK.

The recent reduction in nurses entering the UK is partly due to a decrease in demand and partly to a change in NMC requirements. A new Overseas Nurses Programme and English language tests are limiting the number of successful applications from some countries. In addition from February 2007 the pass mark for the English language test has been raised, which will cause further restriction to entry. Whilst decreasing flexibility in manpower planning this is an important step in ensuring quality and safety in provision of healthcare.

Health Care Assistants (HCA) are becoming an increasingly important part of the workforce. They work alongside trained nurses, who are accountable for HCAs work, and receive training and vocational qualifications. Some student nurses work as HCAs during their training to supplement their finances. The number of HCAs has more than doubled since 1997.

Over recent months financial difficulties and deficits in parts of the NHS have led to short term measures, such as redundancies, recruitment freezes and reduction in temporary staff use. This has had greatest impact on newly qualified nurses, who are now finding it more difficult to secure employment on qualification.

The significant growth in commissioned training places between 1999-2000 and 2003-4 provided an increase of 5,577 training places. Because of funding constraints there is a marked decline in training places commissioned in 2006-7 in the region of 10-30%. In Scotland planned reductions are 5% lower than in the previous year. However, workforce planning is more stable in Scotland, being directed by the Student Nurse Intake Planning exercise.

Staffing cuts have led to a reduction in available nursing hours. Some of this may be covered by current staff working additional hours. The RCN ward staffing review published in March 2007 reported that general medical and surgical wards were running at 14% below the planned establishment, and that a third of medical wards were running with 20% less staff than planned. Despite a ban on the use of bank and agency staff, 51% of wards had temporary staff on duty at the time of data collection. Recruitment freezes were reported by nearly half of the wards surveyed and three quarters were

filling gaps in staffing by existing staff working longer hours. The proportion of registered nurses in establishment and on duty was less than in 2003. 60% reported that shortage of staff compromised quality of care on at least one or two occasions per week.

Significance of the change in age profile of the workforce

The shift in the age profile of the nursing workforce is partly a result of general population ageing and a reduction in nurses trained in the 1990s, and partly a result of policies aimed at attracting people back to nursing and encouraging older first entrants to nursing. However, older nurses who are on the register are less likely to be actively employed, and those who are participating in the workforce are less likely to work full time. In addition, older nurses are more likely to be working outside the NHS in nursing homes and as practice nurses. Within the NHS there are a greater proportion of older nurses working in the community as District Nurses and Health Visitors. The impact, therefore, of a greater number of nurses retiring over the next decade will be most apparent in the community. If nursing numbers are not maintained this will then impact on acute care sectors of the NHS as competition for staff grows.

Policies to aid retention have included a review of the NHS Pension scheme with agreement to maintain a final salary scheme and have larger contributions from employers. This has gone alongside more general retention policies aimed at making the working context more flexible and family friendly (Improved Working Lives Programme), as well as review of the pay and career structure in 'Agenda for Change'.

The issues surrounding an ageing population and workforce are not unique to the UK, as other English speaking countries such as USA, Canada, and Australia are also likely to experience shortfalls in the nursing workforce in the future. There will, therefore, be increased competition for registered nurses with countries such as USA actively seeking to recruit experienced nurses.

THE MEDICAL WORKFORCE

The policy of expansion in the NHS has included the medical workforce as well as nursing. The government's targets for increasing the number of consultants and GPs will be achieved by 2008. Historically the UK medical training system has tended to under-supply doctors but the expansion in medical school places since 1997 means that there is a potential scenario of oversupply. Indeed, NHS Employers (2006) believe that there is a case for planning for a modest oversupply to allow for greater flexibility.

UK medical staff has, in the past, relied on overseas doctors to maintain the workforce but changes to the immigration rules in 2006 for postgraduate doctors and dentists mean that immigrant doctors now have to meet the requirements of an employment category, such as the work permit provisions. However, there will likely be increases in doctors from EU countries as movement between EU countries becomes easier with the EC Directive on

Mutual Recognition of Professional Qualifications which becomes effective in October 2007.

But, in addition, by 2009 the NHS will need to comply with the European Working Time Directive, which will require junior doctors to work no more than 48 hours per week. This will need to be implemented without additional funding and a Hospital at Night model is being developed which will provide out of hours cover in hospitals. This will, however, also be supported by development of nursing roles as substitution for junior doctors.

Recent financial difficulties have led some organisations to take a short term approach to workforce planning which may result in a shortfall in the nursing workforce in the next decade if measures are not taken to address the issues more strategically. There are further difficulties for planners, however, as little is known about:

- the retirement behaviour of nurses or the impact of policies to retain nurses in the workforce.
- accurate statistical data of where newly qualified nurses take up employment both within and outside the NHS
- the dimensions of the non NHS labour market and the flow of nurses between NHS and other employers
- how many of the overseas registrants are actually working in the UK
- the pattern of 'cross border' flow of nurses within the UK
- vacancy rates across the four countries.

Whilst government policy and funding has led to expansion in the NHS in the first years of this century, it is clear that impetus needs to be maintained in recruitment and retention of nurses to maintain the workforce, despite current financial difficulties. Pre-registration nurse education must continue to be accessible and attract people into the profession. Apart from the numbers of nurses needed in the future, account also has to be taken of the structure of healthcare in the future and the type of nurses that will be required. The time lag between commissioning of training places and output of trained staff is lengthy, being up to seven years for a nurse, and so it is important to predict how healthcare may be organised in the future. The following section explores the role of the future nurse.

Summary

- The nursing workforce is aging. By 2015 more nurses will be leaving the profession. This will affect community nursing first.
- There may be more nurses entering the country from the EU, but there will be competition for experienced UK nurses from USA, Canada, Australia and New Zealand.
- Financial difficulties in some parts of the NHS have resulted in vacancy freezes, redundancies, and reductions in nurse training places in the affected areas. Newly trained nurses are hardest hit.
- Policies have sought to improve recruitment and retention and these must be maintained to avoid potential nurse shortages in the future.
- Nursing roles have developed partly as a result of medical workforce issues such as the European Working Time Directive, which is reducing junior doctors hours.
- Health Care Assistants are becoming an increasingly important part of the workforce

THE FUTURE NURSE

The recent situation of 'boom then bust' in some areas has underlined the need to be able to use staff more flexibly rather than to have redundancies in some areas and shortages in others, as the organisation of healthcare changes. High turnover in itself allows flexibility but is costly in terms of identifying, selecting and training nurses and has been linked with decreased productivity and poor quality patient care (Simoens, Villeneuve and Hurst 2005). This flexibility underpins much of the policy that is impacting on the perceived role of the future nurse. The requirement for flexibility is fundamental to the consideration of nurse education, which must prepare nurses to a level that can then act as a foundation for the development of diverse careers and which also allows movement between roles, both within and outside the NHS. The current 'branch' system limits flexibility by setting nurses on particular career pathways at the beginning of their careers, certainly psychologically if not in practice.

Another key issue is increasing specialisation, and one proposed approach to retaining newly qualified nurses is to have accelerated development plans to up-skill band 5 and 6 nurses into specialist roles, allowing newly qualified staff to take on more generic posts. This suggests that nursing careers will take a pathway from generalist to specialist in a similar way to medical careers. Doctors now join at the newly implemented foundation level of two years practice obtaining experience in a variety of settings. Policy documents proclaim the need for a better balance between generalist and specialist nurses, but this creates difficulties for planners in anticipating what proportions represent a 'better balance' and what is meant by specialist and generalist. To shed further light on this, consideration will be given in the following section as to what roles nurses will be playing in the future and further discussion on definitions of generalist, specialist nurses will be given later.

The Changing Nature of Nursing

A report from the Chief Nursing Officer for England *Modernising Nursing Careers – setting the direction* maps out the future shape of nursing in response to Government priorities in healthcare policy. As has been demonstrated in previous sections of this report, healthcare is moving away from a secondary care focused arena, to one in which primary and community care is central. Greater emphasis is being placed on public health and preventive medicine in a health service that maintains health and well being rather than steps in to deal with individual sickness events. As part of this there is a greater emphasis on chronic health conditions and self care. Healthcare is also aiming to be more responsive to patient needs and expectations. People will be expected to take a greater role in their own health management, which will require people to have greater access to information and active participation in healthcare. This will involve working with families and lay carers. However, the other side of the coin to this is the need to provide greater choice for patients with more care being available closer to and within the home.

In mental health nursing, one of the key drivers of change over the next decade nursing is the concept of 'recovery'. This has been identified by the Welsh Assembly Government (WAG 2005), the Scottish Executive (2006) and the Department of Health (2006) as the underlying approach to mental health care in the future. Recovery based approaches require a new way of working with service users which is much more collaborative than has been the case in the past. For nurses to deliver on this agenda it will be necessary to build on the work that has been incorporated into the Fitness for Practice curriculum and develop new ways of opening dialogue with service users to approach their care in ways that are meaningful for them, rather than simply ascribing symptoms to their experiences.

The on-going debate on human rights will also affect mental health nursing. In particular with a new Mental Health Act for England and Wales in October 2008, nurses will need to take a much more central role in ensuring that the human rights of people in care are addressed. In particular the basis for preparing nurses to go on to undergo Approved Mental Health Practitioner (AMHP) training will be of paramount importance. The values and attitudes required of the AMHP will need to be underscored during pre-registration training.

Mental health nursing will also need to respond to the changing burden of disease described in the Chapter 1. This will include, for example, the increase in people with Alzheimer's disease and other dementias, and the increase in dual diagnosis (mental health problems with co-existent substance misuse).

It is also possible to identify a number of factors which will exert an important influence on learning disability nursing. The numbers of young adults with very complex needs are rising as are the numbers of older people with learning disabilities. Both of these groups are likely to present a number of

challenges to services and will inevitably require high levels of support from specialist professionals such as learning disability nurses. There will be continued emphasis on greater service user and carer involvement in the planning and development of services at both an individual and client group level, through initiatives such as person-centred planning and direct payments. Improving access to mainstream health care services for people with learning disabilities remains a constant challenge and learning disability nurses will continue to play a key role in this area.

Children and young people's (CYP) nursing will also have to engage with a number of new and perennial challenges. It will be important that CYP nurses have the skills to engage and hear the voice and views of children, young people and their family. This will facilitate necessary changes to services and their mode of delivery to ensure that service consumer needs and priorities are addressed effectively.

There are new threats to the health and well-being of children in our society. The rapid increase in numbers of children who are obese underscores the need for CYP nurses to engage with public health work to strengthen and improve the health of children and young people. The growing significance of psychological discomfort and mental ill-health among children reinforces this need. As more and more children survive chronic illness and severe disability into adulthood, the ability to manage transition between services will increasingly become a key skill of CYP nurses. Care strategies that are designed to meet the holistic needs of families with a child with enduring health needs will form the cornerstone of children's nursing services.

In addition to the distinctive needs of particular client groups (such as children, and those with mental health and learning needs), patient pathways, cutting across primary and secondary care, are gaining in importance. Many of these emphasise the importance of care outside acute hospital settings. More nurses, therefore will be required to work in community settings and to work across sectors with the boundaries between health and social care also becoming blurred. It has been suggested that all nursing experience should begin in the community, as opposed to the present organisation of nursing in which nurses commence their careers in hospital settings. Taking a more holistic approach to patient care will involve multidisciplinary team working, and professional boundaries will also become blurred. Nursing careers, in the past, were clearly delineated by nursing titles, but these will become of lesser importance than role descriptors.

Nurses will have greater opportunity to take a leading role in the service and to take on activities not previously within their remit. They will become leaders of multidisciplinary teams. Changes in the law now allow nurses to lead primary care practices and to become partners in general practices. Around 50,000 nurses can carry out limited prescribing of medications and around 7,000 can prescribe from the whole *British National Formulary*, an activity previously the remit of medical staff only. In various specialist areas nurses are taking on other roles previously carried out by doctors such as running endoscopy clinics. Blurring of boundaries is taking place not only

across medicine and nursing but also across nursing and other professions such as psychology and physiotherapy, and some believe that there is the danger of losing sight of the core essence of what 'nursing' is. In Scotland, the Scottish Government demonstrates a philosophy for future healthcare in line with that described i.e. a model of care geared more to long term conditions embedded within the community, an emphasis on team based approaches, and greater individual responsibility for health. However, the planned expansion of nursing roles that accompanies this healthcare policy includes an emphasis on maintaining the uniqueness of the nursing identity whilst promoting flexibility, and attempts are made to identify the core principles of nursing with caring being central.

The aim of flexibility not only applies within clinical settings, but also between service provision and academia. There is an awareness that the aging workforce will have an impact on nurse educators as well as clinical nurses and there is a need to build flexibility into the two settings. Joint appointments and secondments are becoming more common across service and education. Nurses are also being encouraged to become more entrepreneurial and to work across the independent and public sectors.

Flexibility within and between roles will involve an expanded working environment and client groups and with the focus changing from and individual event based context nurses will need to consider wider determinants of health and illness prevention. This will require nurses to balance competing demands and to take a wider view of the ethical implications of their actions, and nurse education must ensure that nurses are equipped to deal with ethical dilemmas.

In conclusion, nurses will:

- have a more extended remit and work in increasingly specialist roles
- work across sectors around patient pathways
- need to take on public health roles and consider community needs
- be key workers in the care of chronic conditions
- have the flexibility to move between roles
- have strong leadership qualities to lead, co-ordinate and commission care,
- work across professional boundaries
- work with families and lay carers
- work more independently and have greater accountability

These roles will require a high level of critical thinking and problem solving. In addition they will need to work with increasing advances in technology. Nurse education, therefore must prepare nurses to work in an increasingly sophisticated healthcare environment and equip them for high levels of autonomy on registration. There are also calls for inter-disciplinarity in education to support interdisciplinary working. In many cases joint education between doctors and nurses would appear appropriate.

Summary

Policy proposes that:

- Flexibility of the nursing workforce is a key element for the future.
- There will be an increase in specialist and advanced roles.
- There will be blurring of professional and sector boundaries and titles based on descriptors of role.
- Care will be responsive to patient needs, following patient pathways and dependent on multidisciplinary team working and education
- Nurses will have the opportunity to direct and lead care both within and outside the NHS, with greater entrepreneurial opportunities.
- There will be a greater emphasis on public health and preventive medicine with nurses at the forefront of this initiative
- Care will be focused in the community with the suggestion that this should be the focus for nursing career pathways.
- Nurses will be required to have a high level of knowledge, critical thinking, and autonomy at registration

SPECIALIST AND ADVANCED PRACTICE

There has been considerable debate within the nursing literature concerning the nature of specialist and advanced practice nursing. This is a result of a slowly evolving increase in the development of various nursing roles and titles all representing some degree of specialisation and/or advanced practice and, based on present government policies, this is likely to continue to increase in the future. If nurses are to be the profession to take on these specialist roles, there must be the appropriate educational and regulatory infrastructure in place to accommodate this in a safe and effective manner.

Part of the debate addresses the nature of this change in nursing roles, and whether it can be considered a natural progression of the profession in a 21st century context, or whether it results from a need to limit labour costs by providing a cheaper alternative to medical care. This goes to the heart of the debate of what nursing is, which is a question that has successfully eluded the profession to date, and which will become more difficult to answer as professional boundaries become increasingly blurred. Indeed, the recent NMC definitions of advanced practitioners with role expansion involving physical examination, making a final diagnosis, carrying out treatment and prescribing are difficult to distinguish from that of doctors roles (Wiseman 2007).

The more immediate, practical issues concern how specialist and/or advanced practice can be defined in order to provide adequate educational preparation, to maintain standards, and ensure care is delivered safely to patients. There appears to be some consensus that whilst advanced practice involves specialisation or care to a specific group of patients with complex needs, some specialised roles may be defined by the extension of skills (sometimes carried out by other professions) without advanced practice. Some do propose that it is possible to envisage an advanced generalist. Advanced practice is considered to involve attributes such as a high degree of

autonomy, critical thinking, and the application of a synthesis of knowledge, research and professional leadership to improving the health of those in his/her care (Bryant-Lukosius et al. 2004).

Numerous advanced and specialist nursing titles are in evidence, some of which have come into being in an *ad hoc* way whereas others have been developed more strategically. In 1992 the first students graduated from the Royal College of Nursing Nurse Practitioner Programme, and many more have followed in their footsteps. Subsequently there has been the introduction of Nurse Consultants, and Community Matrons. Whilst these titles represent specific groups of nurses, there are many undifferentiated Clinical Nurse specialists and Nurse Specialists representing a wide variety of roles.

In 2001, the UKCC published their 'Standards for specialist education and practice' which defined specialist practice but not advanced practice. In this document specialist practice was proposed to require the exercising of higher levels of judgement, discretion and decision making in four broad areas of clinical practice, care and programme management, clinical practice development and clinical practice leadership. They noted that there is a clear difference between practising within a specialty and holding a recordable qualification of specialist practitioner. This definition, therefore, addresses a level of advanced practice within specialties, thus blurring the distinction between specialization and advanced practice.

The RCN undertook a survey in 2005 to assess the types of job carried out by nurses with titles suggestive of advanced practice (e.g. Nurse Practitioner or (Clinical) Nurse Specialist) and whether roles could be categorised. They found that post holders typically spend most of their time in clinical work but many carry out education, research and management activities as well. There were certain core activities carried out by most responders, which included patient assessment and referral, autonomous decision making, and offering specialist advice and education. Based on inter-item correlations and factor analysis they grouped the activities under three headings: case management, diagnosis and organisational activity. Organisational activity included leadership activities, providing education and initiating research. They found that the different types of nurse varied in the mix of activities that they undertook. Clinical Nurse Specialists and Specialist Nurses viewed case management or care co-ordination activities as central to their role (although they actually carried out less of this activity overall than other categories of nurse such as nurse consultants). Nurse practitioners viewed case management activities and diagnostic activities as the activities that differentiated them from other nurses. Nurse consultants viewed diagnostic and organisational elements as key to their role, and Advanced Nurse Practitioners saw the diagnostic role as central. They therefore considered there to be four types of post, distinguished by the activities they carry out: specialist nurses/clinical specialist nurses, nurse practitioners, advanced nurse practitioners and nurse consultants. Making diagnoses appeared to be a key differentiating activity with more than 90% of consultant nurses

diagnosing, about one third of clinical/specialist nurses, and about four fifths of nurse practitioners and advanced nurse practitioners.

The career path towards being an advanced practice nurse is not clear. When respondents in the RCN study were asked what preparation was required for advanced posts most suggested a combination of relevant experience and educational preparation although there was no consensus as to what either of these involved. Career pathways in nursing must be considered as part of the new pay and career structure developed in *Agenda for Change*, which is linked to the Knowledge and Skills framework (KSF).

Agenda for Change provides a career framework for NHS staff including nursing, midwifery and allied health professionals. There are nine levels ranging from level 1, initial entry posts, to level 9 who are Senior Managers. Consultant Practitioners are at level 8. The Knowledge and Skills framework is used to assess development so that staff may progress within pay bands. Movement between pay bands depends on the grading of the person's job. One of the aims is to remove rigid professional demarcations allowing staff to move between roles within a pay band. It also places importance on continuing professional development, which is mandatory for nurses to maintain their registration.

Continuing professional development requires a partnership between service and education and nurses require supervision and support to allow them to continue their professional development. This is a problem for some advanced practice nurses who have become very specialised in their practice and for whom there is no-one with the appropriate type of expertise to give them adequate professional support.

In addition, at present it is difficult to define the level of education required for advanced practice when basic level education at point of registration is not standard. Some would suggest that further education for advanced practice should depend on the previous level of attainment, and could be at honours, masters or doctorate level. This approach has obvious difficulties in setting standards as the type of study at undergraduate and postgraduate level is quite different and until there is clarity concerning pre-registration education it is difficult to foresee clarity emerging for advanced level.

Whilst the Knowledge and Skills framework attempts to be all inclusive, again with a primary aim of flexibility of the workforce, detailed consideration is being given to how this applies to nursing, in all its potential guises. The Republic of Ireland (ROI) has taken a different approach to developing nursing career pathways in order to avoid the confusion inherent in the UK system. Along with countries such as Australia and New Zealand, ROI has adopted a strategic role development approach by setting up The National Council for the Development of Nursing and Midwifery (NCNM) to specifically monitor nursing and midwifery career pathways, and ensure consistency in role developments.

In ROI all nurses are educated to degree level, following which they become a generalist nurse or midwife. The career pathway leads from the generalist to specialist to advanced practice, and these levels are linked to educational preparation, responsibility and autonomy. Clinical specialist educational requirements are higher or postgraduate diploma level, and advanced nurse practitioners are educated to masters level. The NCNM must approve all specialist and advanced posts, and also individuals who are appointed to posts with approval lasting for as long as they are in post (re-accreditation must be gained after five years). In this way they ensure that advanced practice posts are integrated into healthcare organisations so that specialist and advanced practice nurses do not become isolated. However, the NCNM is not prescriptive on where or what sort of posts should develop as this is based on patient need. In addition titles of posts already in existence were standardised in accordance with the framework. In the UK, however, titles are to become less important than descriptors of the role carried out by the nurse. It could be debated as to whether this will aid transparency for the public, in terms of knowing what level of practice to expect from particular nurses.

The implications of standard titles should not be underestimated, as they are linked to status, remuneration and contribute to the holder's self esteem, as well as being a shorthand for planners to indicate the level and breadth of responsibilities associated with posts. At present, however, there is even confusion amongst other health professionals as to the level of practice of advanced and specialist nurses, which acts as a barrier to fulfilling roles. These issues are now being addressed, and the NMC intends to open a sub-part of the Nurses part of the register, subject to Privy Council approval, with a definition of advanced nurse practitioner, which means that the title will now be protected. But, this does not prevent employers still developing many varied posts and titles depending on local service configuration and need. It has been proposed, however, that these sit within an overall nursing framework (apart from the KSF) that provides some uniformity regarding relative experience, qualifications, competence, and responsibility. A consultation document by the Chief Nursing Officer for England in 2004 recommended a much more structured approach to preparation for advanced practice, in order to avoid the 'ticket collecting' approach that has characterised a good deal of post registration education. This report suggests that the need for advanced posts is identified and candidates selected and sponsored to follow a recognised educational pathway (to masters level). In this way preparation can be standardised and employers more likely to fulfil their commitment to protected study time.

In Scotland a strategic view of role development is demonstrated with importance placed on the evaluation of new roles and demonstration of effectiveness, as well as the need to disseminate findings. Buchan and Daz (2002) noted the dearth of research in the UK into how roles are introduced their prevalence and effectiveness. The approach in Scotland also points to the need for new roles to be adequately resourced with consideration being given to sustainability, to ensure that posts are funded for sufficient length of time to allow post-holders to achieve a level of success before evaluation is carried out. This approach would help prevent new roles cropping up in

response to small injections of money from various sources, with little hope of sustainability.

In Northern Ireland there is a strong public health agenda with an emphasis on the growing role of community nursing and policy papers direct development and redesign of community nursing. Similarly to England this sees nurses increasingly as the first point of contact for patients and clients, with flexible working across boundaries using a wider range of competencies and a greater variety of roles. The role of nursing leadership and autonomy is again stressed. This was tested out in eight pilot projects, which involved evaluation, thus taking an evidence-based approach to development of nursing roles. Results of the evaluation questioned the appropriateness of the branch system of pre-registration nursing education (Dept of Health, Social Services and Public Safety, 2006 p40). Participants in the study felt that changes were needed to both pre and post registration training to include adequate generalist preparation and an increased community nursing content. It was proposed that education and development should be based on the three core domains of First Contact Care, Continuing Care and Public Health. An educational skills escalator approach was supported with a three tier model of Foundation (Novice), Experienced (Disease Specific) and Advanced level of practice, an approach which favoured step on step off options.

In Wales the future direction of healthcare was triggered by a review carried out by a project team chaired by Derek Wanless in 2003, complementing the similar review carried out for England. The review found that due to underlying socio-economic factors the health of people in Wales is poor compared to the UK overall. There was also huge variation in performance between NHS trusts and primary and social care providers, and expertise was spread too thinly to meet quality standards. It was recommended that relationships be developed with education and training institutions to improve professional standards and provide enhanced training for all staff. This emphasis on education has resulted in Wales being the only one of the four countries that has an all graduate entry to the nursing profession (discussed in the following section).

Nurses who expand their role to take on tasks currently undertaken by another healthcare professional must perform the task to the same standard of ordinary skill (the Bolam test). In order to ensure nurses are adequately prepared for their practice a method of assessment involving measuring competencies has been developed. For Advanced Nurse Practitioners there are 124 competencies that have been aligned to the Knowledge and Skills framework, and for Community Matrons there are 9 domains which are subdivided into 57 competencies containing a total of 1061 performance criteria (Wiseman 2007). It is unclear how these will be assessed or who will assess them, and whether this system is tenable, although this type of approach is perhaps a safer option to self assessment of competency as roles become increasingly advanced.

The Family Nurse pilot in Scotland has developed a new model of community nurse focusing on the family rather than the individual in order to include in

practice a consideration of the wider determinants of health. This was developed to address the difficulties in providing primary care services in remote and rural areas. Prior to the pilot, triple role nurses were employed, but recruitment and retention proved difficult. It also addressed the difficulties of providing advanced generalist practice by providing a toolbox of specialist roles. It began by developing an educational programme for experienced nurses and provides a successful example of emerging advanced generalist roles.

The NMC's proposals to open a sub-part of the nurses register for advanced practice is in line with the White Paper on 'The Regulation of Health Professionals in the 21st Century'. This White Paper sets out to bring regulation of health professions more in line with each other. Responsibility for educational standards remains with the NMC and included in the White Paper are proposals for standards for higher levels of practice with particular reference to nursing. It also points to the role of employers in contributing to the process of revalidation of professional registration, as part of normal staff management and clinical governance systems. Information gathered as part of the Knowledge and Skills Framework is proposed to be the basis of revalidation. However, alternative models of revalidation must be established for nurses who are self employed.

Summary

- Continued increase in specialist and advanced practice roles.
- Blurring of professional boundaries questions whether nurses will be able to maintain their professional identity.
- There needs to be clear definitions of advanced and specialist practice to facilitate planning, educational preparation and regulation.
- There is a lack of clarity concerning the career pathway to advanced and specialist roles, but frameworks have been developed for Health Care Professionals (Agenda for Change and the Knowledge and Skills Framework) which provide an overarching framework for career development processes.
- Within Agenda for Change and the KSF, continuing professional development is an important requisite.
- Nurses in advanced practice may have difficulty accessing supervision and support for continuing professional development. Assessing competencies may also be problematic.
- There is debate concerning the appropriate level of education for advanced level practice and this is linked to pre-registration educational requirements.
- The NMC will establish registration of advanced practice.
- Regulation of health professions is being revised which has commenced with the White paper on 'The Regulation of Health Professionals in the 21st Century'. The NMC currently remains responsible for setting educational standards for pre and post registration programmes.
- Drivers to change are similar across the four countries, but with some variation in demographic demands and emphases of different aspects of policy e.g. Wales the only country with all graduate entry to the profession.
- A developing role for nurses with more advanced and specialist practice.
- There is agreed emphasis on community nursing and organisation of care.
- There is variation in strategic planning of nursing role development with greater emphasis on consistency, planning, and evaluation in some quarters.

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CHAPTER 3

NURSE EDUCATION: KEY DRIVERS

This chapter looks at the changes in nurse education in the last decade and discusses the main factors that may impact on developments in the future. The recent history of nurse education is discussed, most notably, the introduction of nursing into Higher Education and the implementation of Fitness for Practice. In addition, the wider policy implications outside the profession such as recruitment and retention and European perspectives are introduced.

Background

Nurses have an important role in meeting the health care needs of a changing population. It is therefore necessary to invest in appropriate nurse education to meet these needs. Despite the rapid changes in nursing education, we still grapple with the same healthcare reform issues. Discussions at the first Nurse Education International Conference (2006) highlighted that the challenges for nursing are consistent globally and include a shortage of nurses, an ageing professional workforce and the financial constraints of funding nurse education. There was also concern that the principle of caring is no longer fully integrated into nursing curriculum and could be potentially overlooked in the future.

Until the 1980s, nurse education was traditionally embedded within the NHS. The apprenticeship model enabled nurses to learn their trade 'on the job' as schools of nursing were attached to hospitals and provided the professional education necessary to support healthcare needs. This model provided a practice based workforce, however it was criticised as it was questioned whether the preparation met the needs of a changing health service. Consequently, a number of significant changes occurred in nurse education, the most radical being the introduction of *Project 2000* in 1989. NHS schools of nursing were integrated into higher education in the early '90s and by 1997 the move to higher education was achieved. Student nurses became supernumerary and were no longer classified as NHS employees. *Project 2000* introduced the branch structure for pre-registration nursing programmes based on four patient groups; Adult, Mental Health, Child and Learning Disability. The branches were introduced due to the perceived limitations of generalist nursing, primarily whether a generalist nurse could work effectively with specific patient groups. There were also fears that more generalist roles would lack appropriate support and professional development which would impact on the care of specific patient groups.

Project 2000 aimed to introduce a more critical approach to nursing, moving away from the perception of nurses carrying out routine clinical practice. An

increase in theoretical components of nurse education was generally well received; however the increasing theory-practice divide is often attributed to the move of nurse education into Higher Education. There were concerns that focusing on theoretical aspects of nursing impacted on clinical skills, consequently, it was questioned whether nurses gained adequate preparation to carry out the required skills in practice.

In 1998, the UKCC established a Commission for Education, chaired by Sir Leonard Peach, which aimed to 'prepare a way forward for pre-registration education that enables fitness for practice based on health care need' (UKCC, 1999). An extensive consultation exercise across the UK revealed evidence of good practice, but also recognised that there were problems impacting upon fitness for practice at the point of registration. Although some issues were common, the Commission identified differences between nursing and midwifery and between the four countries of the United Kingdom. The final report, *Fitness for Practice* (FfP) was published in 1999 and provided key drivers for change in pre-registration nursing and midwifery curriculum. The major recommendations arising from the report focused on increasing flexibility, achieving fitness for practice and working in partnership.

A major shortcoming of *Project 2000* was the question of whether nurses were indeed fit for practice on the point of registration. Consequently, the Commission recommended that pre-registration education should focus on outcomes-based competency principles, developed by HEIs and service providers, which were responsive to the needs of clients in different healthcare settings. It was also recommended that a period of supervised clinical practice of at least three months towards the end of the pre-registration programme would enable students to consolidate their education and competence in practice. The Common Foundation Programme (CFP) was shortened to one year due to the overemphasis on adult nursing. FfP branch programmes therefore currently comprise two years with generic competencies for entry to the professional register.

Following the introduction of FfP, the Post Commission Development Group (PCDG) focused on two important issues that needed additional attention. These included the development of inter-professional education and the need to review the current branch structure of pre-registration nursing education. The PCDG used a variety of strategies to inform the review which included searching and analysing relevant literature, commissioned work, away days, focus groups and wider consultation. The PCDG presented six possible models for future pre-registration nursing education. The frameworks were developed in the light of the key trends presented in *Healthcare Futures 2010*. It was however acknowledged that no immediate changes to the branches would be implemented as there was a need for a period of stability for the new FfP programmes. Each of the proposed six models was devised in relation to the model's responsiveness to patient need, inter-professional opportunities, feasibility, regulatory and resource implications. The models included:

- Model 1 The existing four branches of nursing enhanced - practice experience divided equally between hospital and community settings.
- Model 2 Four branches of nursing integrated with social care.
- Model 3 Six branches of nursing – additional branches of older person and community.
- Model 4 Two branches of nursing – adult and child
- Model 5 Two branches of nursing – hospital and community
- Model 6 The generalist nurse, with specialisation following registration

The proposed models have been the subject of considerable debate culminating in the NMC's current review of pre-registration nursing education in progress by the NMC. The ongoing review of Fitness for Practice at the point of registration comprises three phases. Phase 1 focused on changes needed to strengthen fitness for practice at the point of registration, support for new registrants post-qualification and the simulation and practice learning project. This involved the establishment of Essential Skills Clusters (NMC, 2006a) to complement existing proficiencies for entry to the NMC register (NMC, 2004); and the development of standards to support learning and assessment in practice (NMC, 2006b). Phase 2 targets issues around general entry and selection, good health and character. This report will inform the work in Phase 3 which aims to explore, consult, develop and finally publish new NMC Standards of Proficiency for pre-registration nursing education.

Fitness for Practice Programmes

The first FfP students completed pre-registration programmes in 2004, however it is difficult to determine the success or otherwise of the programmes given the range of policy and professional issues that have occurred. Scholes *et al.* (2004) conducted the most extensive evaluation of FfP to date. This Department of Health funded study evaluated 16 demonstration sites in England to identify whether *Making a Difference* and FfP enhanced the skills of students, to explore developments in partnership working and examine changes in career pathways. The findings revealed evidence of partnership working, specifically a greater shared responsibility for student learning. The researchers concluded that further research would be needed to examine whether FfP programmes produce nurses who are fit for practice on the point of registration.

The Welsh Assembly Government and NHS Education for Scotland also commissioned evaluations of FfP in 2005. Preliminary findings from an Evaluation of the All Wales Fitness for Practice Initiative demonstrate that joint commitments from HEIs and HCPs are a major factor of its success. The Scottish evaluation is well underway in exploring the strengths and weakness of the pre-registration programmes, specifically the impact on skills and competencies of the newly registered practitioners. The study is due for completion in Spring 2008.

Evaluative work is vital to inform future developments in nurse education. Early indications illustrate that Fitness for Practice programmes have improved many aspects of pre-registration education, however it is still unclear whether new registrants are indeed fit for practice.

Summary

- *Project 2000* introduced the Branch structure to nursing education
- Fitness for Practice (1999) aimed to prepare a way forward for education based on health care need
- UKCC Post Commission Development Group (2001) focused on inter-professional education and the need to review the branch structure
- First FfP students completed pre-registration programmes in 2004
- National evaluations of FfP reveal evidence of partnership working
- Further evaluative work needed on whether FfP registrants are fit for practice

Access to nurse education – recruitment and retention

Chapter 2 of this report highlighted the number of nurses joining the register and those leaving. Since the start of this millennium there has been a steady increase in the number of new registrants. Nearly 31,500 nurses joined the NMC register as initial registrants in 2006, of which two thirds undertook pre-registration training in the UK (Table 3.1).

Table 3.1: NMC Statistics 2006c (UK registrants)

Country	2002	2003	2004	2005	2006
England	11,712	14,616	15,862	16,146	16,848
Scotland	1,786	2,238	2,331	2,263	2,434
Wales	647	810	812	1,159	962
Northern Ireland	393	430	457	414	696

The growth in pre-registration nurses can be attributed to increased government funding, and national advertising campaigns. However, the commissioning numbers have recently been cut for the first time in over a decade. Figures for 2007/8 indicate a reduction from 1,292 to 1,070 pre-registration places in Wales and a freeze on commissioning new places in Scotland in which the numbers were maintained at last year's level of 3,325 places. In England, there was an average cut in numbers of around 10% in 2006-7. Regional variations in England demonstrate that the largest reductions were made to Universities in the South of England. If the trend to cut commissioning numbers continues then this could have serious implications for the availability of newly qualified health professionals. There may also be consequences for staff in HEIs due to potential cuts in academic posts and restrictions on new appointments. Current financial deficits in the NHS have made it difficult for newly qualified professionals to secure employment. Chapter Two highlighted the potential impact that the number of nurses retiring over the next decade may have on the workforce. Nurse education could therefore face further instability if the 'boom-bust' approach to

commissioning continues as the education workforce may no longer be able to sustain the predicted future need for increasing student numbers.

Current profile of students entering nursing

Policy documents are concerned with recruitment and retention strategies with the aim of providing increasing diversity in the workforce. Recent recruitment drives have aimed to widen the base of applicants to ensure that the workforce reflects the service users of the health service and provide a route to Higher Education for a broader range of groups. A flexible approach to recruitment is advocated which aims to address changing health and workforce demands. The NMC supports strategies which facilitate 'stepping on' through APEL opportunities for up to a third of the programme. A widened entry gate has resulted in an increased number of students by broadening the diversity of applicants in terms of age, gender, ethnicity and educational achievements. However, the RCN Labour Market Review (2006) highlighted that applications to pre-registration nurse education continue to increase, yet the rate of increase varies according to country, region and branch.

There is currently no statutory upper age limit for entry to pre-registration nursing; institutions therefore assess each applicant, regardless of their age, as to their suitability for the course. Those aged 26 and above currently account for nearly half (46%) of nursing students. Women account for the vast majority of applicants with men comprising only 5-8% of pre-registration students. In recent years there has been a decline in the number of men applying for nursing which accounted for 21% of applications in 2001 and only 13% in 2005 (NMAS, 2005). There is also a slight change in gender by Branch as 47% of Mental Health and Learning Disability students were male in 2005 compared to 42% in 2002. It is estimated that 18.9% of qualified nursing, midwifery and health visiting staff working in the NHS in England in September 2005 were from minority ethnic groups (RCN, 2006). However, applicants from non-white groups have a lower acceptance to pre-registration nursing than white groups, with only 6% of nurses educated in the UK from Black and minority ethnic groups.

Recent educational policy in the UK such as the 14-19 Reform provides radical changes for curriculum, assessment and the choice of education available in secondary schools and colleges. New specialised Diplomas will be offered in England next year to target each sector of the economy and have been devised to facilitate progression to higher education or career options (DfES, 2005). The Diplomas offer an integrated approach which combines theory and learning applied to a working environment, which may provide an appropriate route for those wishing to apply for pre-registration nursing. The reform further reinforces the aim to increase participation rates of those in full-time education post-16. In Wales, *Learning Pathways* provide a framework to tailor learning to approved qualifications, whilst offering flexibility, core skills and regular support for learning and careers advice (WAG 2004). A Welsh Baccalaureate Qualification has also been piloted with 16-19 year olds and a staged roll-out is anticipated in Autumn 2007. Scotland does not have a specific strategy for 14-19 education, yet introduced A

Curriculum for Excellence (ACfE), a single-phase curriculum for ages 3-18 (Scottish Executive, 2004). ACfE aims to provide wider opportunities for learning and to facilitate the transition to further learning, training or employment. The Entitlement Framework is a key driver of the 14-19 reforms in Northern Ireland and will become Statutory in 2009. Students will be able to study for academic and vocational subjects from a minimum of 24 available. A review of the curriculum and qualifications is imminent, which will determine whether a diploma approach will be developed in Northern Ireland.

Clearly, the routes to Further/Higher Education and employment are expanding. There is currently a tension between policies to widen access to education and the possibility of introducing a degree level programme. Introducing graduate level programmes may present difficulties for some of the traditional applicants such as HCAs who may no longer be able to access nurse education. It is important to update the image of nursing so that it can compete with other attractive careers.

Summary

- Overall, steady increase in pre-registration nurses, yet recent commissioning numbers have been cut
- Recruitment and retention strategies aim to provide increasing diversity in the workforce
- Applications to pre-registration nursing continue to rise
- 14-19 reform introduced radical changes in secondary education in the UK
- Routes to further/higher education and employment are expanding
- Need to update image of nursing so that it can compete with attractive careers

Structure of pre-registration nursing

The debate over the structure of pre-registration nursing has escalated in recent years. The definitions of roles and their associated boundaries have become blurred. The Commission for Education (2001) made clear that the current programme model of four branches of nursing needed reviewing.

Currently, pre-registration students may choose to study in Adult, Mental Health, Child and Learning Disability Branch. A strength of the current programme is that it attracts students who are committed to a career working with particular patient groups. Direct entry to child branch courses ensures that appropriate care is provided to support policy drivers such as national service frameworks (DoH, 2004). In a vision for learning disability nursing, Northway *et al.*, (2006) highlight that pre-registration education must enable students to develop skills to work in direct roles with people with learning disabilities who have complex needs. Recent reviews of Mental Health recommended that pre-registration education must prepare MHNs '*to provide effective and values-based care*' (DoH, 2006) and '*to promote mental health and well being*' (Scottish Executive, 2006).

Future health services may seek more generic workers to meet general health needs in a cost-effective way. This type of preparation could reduce fragmentation, age defined specialism and skills deficits. This could see the introduction of a more generic approach to educating health professionals through inter-professional education (see later section). A generalist, pre-registration programme may be perceived as attractive, if subsequent post-registration specialist training were to be adequately funded. Trends towards generalist training in other parts of the world also support this approach. However, there are strong concerns that generalist nursing would result in a deskilling of the workforce. Advanced and specialist practice may therefore best be provided through a balance of generalists and specialists providing a more integrated approach to care. Such arguments reinforce the need to maintain specialised pre-registration education.

Modernising Nursing Careers highlights the need to prepare nurses who can work in a range of settings with a better balance of generalists and specialists in the form of integrated networks of care. Potential changes to the branch programme need not follow an either/or approach of a generalist or specialist nurses. Some support the need for an additional branch whereby the Adult Branch is split into acute and primary care (Scholes et al., 2004). Other options include a longer CFP programme, more generalist approaches within branches, or a modular system with a generalist approach in specialist areas. A greater focus on community perspectives is already evident at London South Bank University which offers a community-oriented adult branch at pre-registration level. The majority of placements in pre-registration programmes currently take place in hospital settings with a shortage of placements in primary care and independent sectors. A change in branches would therefore have strong implications for the capacity to support additional branch programmes.

Pre-registration preparation will need to address the shift towards community based care, complexity of conditions, new technologies, evidence based practice and patient self-management. It is important to consider to what extent we need to provide skills across a broad range of care and how much specialisation should occur at pre-registration level. There is a definite need for the boundaries and definitions of generalist and specialist practice to be more clearly defined to inform future decision making.

Level of pre-registration award

Currently, nurses can study for pre-registration nursing under the diploma or degree route. Nurses need to be able to possess knowledge and understanding and the ability to critically evaluate the evidence base. It could therefore be argued that nursing education needs to be comparable to other health professionals to Bachelor Degree level at point of registration.

The three year nursing degree was introduced in 1994. Arguments for the degree entry are that bachelor level is more attractive and will recruit more able students. In addition, degree level programmes will enhance the status of nursing in comparison to other health professions and provide nurses with

skills needed that go beyond diploma level. There are also funding implications as many Diploma nurses have to self-fund courses to top-up to degree level which frequently occurs soon after registration. Arguments against degree preparation include a belief that nurses do not need degree level skills to provide quality care which may be at the detriment of more practical skills. There is also concern about a reduction in the diversity of applicants and that the challenges associated with degree level may deter applicants and deny access to a nursing qualification from less qualified health services staff such as HCAs. Initiatives such as bridging courses and part-time courses offer a means of facilitating access to nurse education for HCAs. It would appear therefore that entry to nurse education may be more influenced by HCAs not wishing to give up their salary, rather than the level of entry criteria.

FfP called for an increase in graduate preparation for nursing and midwifery because of:

- the nature of clinical decision making required
- the current demands of service providers, particularly for workforce flexibility and role diversity
- the close approximation of the current diploma preparation to graduate level
- government targets for participation in higher education
- the increasing demand for graduate nursing places but limited supply of places
- the increasingly competitive labour market
- the career expectations of young people

There is indeed growing support that pre-registration training should be at degree level. It is important to gain the views of those commissioning education to ensure that the future model of nursing meets the needs of health care providers. It is acknowledged that the introduction of all degree level courses may impact on the diversity of cohorts recruited in diploma programmes. Wales took the decision to move to all degree level programme in 2004 – early indications suggest that there are still adequate numbers to fill the places for graduate level pre-registration courses whilst maintaining widening access to education. Scotland has also made a firm commitment to an all graduate nursing profession at the point of registration, and some interest has been expressed in this possibility in Northern Ireland. England has not yet made a commitment to this.

Thorne (2006) considers how the changing context of healthcare will necessitate increasing numbers of nurses to be qualified at the master and doctoral levels based on the belief that we need individuals 'who are prepared to deconstruct the ideological claims that are sometimes made on our (nursing) behalf and to help nurses see alternative ways of understanding the world'. Given the increasing emphasis on evidence based practice, the drive towards research qualifications are an important feature of pre and post-registration education.

HCA's carry out a substantial proportion of nursing care. This clearly has implications for the future role of nurses. It is likely that the HCA role may also change and therefore important that HCA's are given appropriate training and clear definition of their role. Nurses of the future will need to develop increasingly sophisticated knowledge and skills. Nurse education must therefore respond to these needs by providing the appropriate pre-registration education in preparing the future workforce.

Summary

- Debate over the structure of pre-registration nursing is ongoing
- Current 4 branch structure focusing on collective groups has been questioned
- Future health services may see more generic workers consistent with training in other parts of the world
- Advanced and specialist practice may be provided through a balance of generalists and specialists providing integrated care
- Various options for the future structure of pre-registration education have been proposed
- Pre-registration education must address the shift to community based care
- Currently, diploma and degree level programmes of pre-registration education
- Arguments to support degree level to enhance nursing
- Arguments against degree level suggest detrimental to more practical skills
- Growing support for pre-registration degree level programmes

Nurse education setting – responsive education

The transfer of nursing education into higher education has required re-orientation of its goals and values and a major expansion in research capacity. A survey carried out by the RCN (Evers, 2000) suggests that pressures from increased workloads are damaging morale amongst nurse lecturers and that many feel unable to provide a first class educational experience for students.

Clinicians and nurse teachers need to keep up to date with current practice in their role as nurse educators. To provide responsive education, educators need to be in touch with current issues in order to provide education that meets the changing health care needs. The importance of integrating theory and practice must be maintained in future nurse education. Practice based learning is integral to nursing – however, initiatives such as simulated learning can also offer valuable learning experiences for pre-registration education.

The challenges of moving nursing into higher education and lack of funding causes problems in attempts to provide responsive education. Far more nurses than doctors are trained, yet funding is not comparable. Nurse education of the future will continue to strive to address the needs and rights of vulnerable individuals, families and populations. This will require an

increase in skills in public health, long-term care, care of older people, and community care.

Service and education must work together to provide quality education. Appointments such as Practice Educators illustrate an increase in roles with an education remit to be practice based to facilitate true integration of theory and practice. Recruitment and retention of the nurse education workforce is also an important concern in the light of competitive posts offered in clinical practice. The future role of nurse educators is likely to change with an anticipated increase in joint appointments between service and education.

The NHS can not afford an all registered workforce (diploma or graduate). The idea therefore could be to substitute a proportion of registered nurses with well trained HCAs. The implication of how and where additional training will be provided is uncertain. If the level is below foundation degree, it would not be appropriate for the courses to be based in HE. The Further Education (FE) sector would be more appropriate. This would have consequences for infrastructure as the FE sector would have to invest in library and clinical laboratory provision. In addition, there would need to be relocation of staff. Salary cost is the highest proportion of education contracts; if HE salaries were maintained then savings would be marginal. In addition, if the majority of nurse training took place in the FE sector, it would decimate the research potential.

Inter-professional education

NHS plans for England and Wales recognised the importance of shared learning for health care professionals to develop integrated care services. There was also clear support for inter-professional learning in nursing, midwifery and health visiting strategies across the UK. The policy commitment to multi-professional team working has emerged into the aim of learning together in both pre and post qualifying professional education. Humphris and Hean (2004) argue:

'In order that patient focused services are delivered, no profession can remain isolated or territorial'.

The Bristol Royal Infirmary Enquiry (2001) also indicated the need for shared education and training to foster respect between professions and to enhance multi-professional team working.

Feedback during the FfP Consultation (2002) period indicated that an inter-professional Common Foundation Programme seemed unattainable. However, the current duplication of teaching is unsustainable. There is evidence of successful inter-professional working between undergraduate nurses, medical social care, occupational therapy and physiotherapy students to name a few (Reeves et al. 2002; Morison, 2003). Several universities provide joint training for nurses and social care students and this approach may increase in the future. However, the practical issues of timetabling and large student cohorts present significant barriers to shared learning. Inter-

professional working can be seen more clearly in practice settings, particularly in the interface between health and social care (DfES, 2003). For example, children's and young people's nurses are strategically placed to provide child-centred care within a family context. The Children's Workforce Network has developed an extensive programme of work to provide joint up services and a common value base for those working with children.

It could be argued that current models present more of a multidisciplinary approach where different groups of health professionals learn side by side, rather than learning with and from each other in the truest form of inter-professional learning. Inter-professional education may be best placed in post-registration contexts as those studying at pre-registration level are still developing an identity within their own profession. However, the slow process of professional socialisation may create negativity between professions. The increase in interprofessional learning may also have implications for the nurse education profession with a move away from profession specific lecturers.

European perspectives

Nursing education must respond to the advances in global communication by providing a curriculum that acknowledges interdependent relations between countries (Shoorman, 2000). To date, nursing programmes have been subjected to two European Directives which state that a nursing programme should be at least 3 year long or 4,600 hours. Academic requirements, including level of award are not stipulated in these directives. Consequently, there is considerable variation in the structure of nursing education across Europe. The NMC strives for education that meets EU requirements and provides equal opportunities and freedom of movement for all students in relation to general care.

Increasing mobility in the EU led to The Bologna Declaration (1999) in which 29 European governments (now 45 participating countries) agreed to establish a European Area of Higher Education by 2010. The Bologna objectives aim to offer accessible and comparable degrees (bachelor, master and PhD), mobility for students and academic staff, co-operation in quality assurance and overall to increase the competitiveness of the European Higher Education Area. Following the Bologna Declaration, a pilot project known as the 'Tuning' Project commenced in 2000 to address the Bologna Process as a collective.

The Tuning Project aims to harmonise nurse education in Europe to enhance the mobility of nurses across Europe. Nurses would therefore study under similar structures of nurse education and therefore be eligible to practice in any member state. The Project involves 101 university departments from 16 European countries. It does not aim to achieve standardisation, and was named 'Tuning' as the project aims to provide a point of reference or common understanding which maintains flexibility in curriculum development. Nursing was evaluated in the second phase of the project which focuses on the Bologna objectives, in particular a system of comparable degrees and, more specifically within this, to develop generic (30) and nursing-specific (40)

competencies for graduates, to offer guidance for curriculum design. Table 3.2 provides details of the Nursing-Specific Competencies.

Table 3.2: Nursing-Specific Competencies (Bachelors degree)

Competencies	Number
Professional values and nursing roles	6
Nursing practice and clinical decision making	5
Nursing skills, interventions and activities	6
Knowledge and cognitive competencies	8
Communication and interpersonal relationships	8
Leadership, management and team abilities	7
Total	40

The European Federation of Nurses Associations (EFN) identified the main challenges for the nursing profession as the need to determine what kind of nursing do we want for Europe? What kind of nursing competences do we want? What are the priorities in the short-term and most notably, how will the Bologna process promote Excellency in the field of Higher Education and research? (De Raeve, 2006). The EFN and International Council of Nurses (ICN) have agreed the following principles in relation to nurse education:

- Admission to nursing is only possible after finishing secondary school (consistent with access to University)
- Length of training should be adequate to achieve specific competencies and should not be less than 3 years (minimum bachelor level)
- One European professional level for nurses
- Curriculum should be based on and comprise research, skills and competencies
- The Director of the Institute should be a qualified nurse

(Adapted from De Raeve, 2006)

There is currently limited information on how to address the range of different cultural issues in practice and how education should tackle these issues in curriculum developments. Attempts have been made to offer an international perspective to nursing curricula, however, cultural identity is often perceived as an additional, rather than integral component of the curriculum (Law & Muir, 2006).

The main implications for the UK are that the Bologna Process supports the introduction of a European Credit Transfer System (ECTS) and that entry to the professional register will be at bachelor's degree level and more specialised education will be delivered at graduate level (post-registration).

Summary

- Nurse educators need to keep up to date with clinical practice
- Service and education must engage in collaborative working
- The structure of additional training for HCAs is unclear
- Policy supports the importance of shared learning
- Some evidence of inter-professional learning
- Nursing subjected to two European directives
- Variation in structure of nurse education across Europe
- Bologna aims to offer comparable education in Europe
- Tuning Project aims to harmonise nurse education and improve mobility of nurses in Europe

Conclusion

It is crucial to consider future funding mechanisms to ensure that nursing education continues to meet the ever changing NHS modernisation agenda. Nurses must be properly prepared, fit for purpose and practice in order to at least maintain and ultimately improve patient care, health and well being in line with health and social care policy.

There is a lack of investment in nurse education at every level, with many qualified nurses funding their own post-registration education and the difficulties of securing study leave to undertake courses. It is predicted that nurse education will increase at both pre and post registration which clearly results in greater expenditure. It is therefore important now more than ever that nurses can justify the importance and nature of their role.

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CHAPTER 4

SCENARIOS FOR UK NURSING IN 2015

Purpose

The use of scenarios is now a relatively well-established approach within strategic planning. Pioneered by the Shell oil company and others, many organisations (including the NHS) have now used scenarios for many years to grapple with the essentially 'unknowable' nature of the future. They particularly gained currency when seismic shocks such as the oil prices rises of the 1970s revealed the inadequacy of linear thinking about the future – the notion that there was only one future, and the task was to analysis trends thoroughly enough to work out what it was. A scenarios-based approach accepts from the start that the future cannot be predicted, and that plans have to be tested against a *range* of possible futures.

There is no one way of producing scenarios. Clearly, they must be evidence-based, and they must describe futures which are not only plausible but actually quite likely. They must also be useful – in this case describing different contexts in which pre-registration nurse education must be fit for purpose. But beyond that, the creation of scenarios is probably more art than science.

Three Scenarios

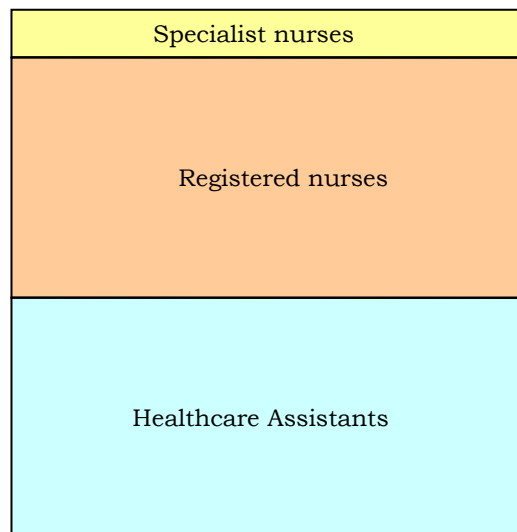
Our intention is that the three scenarios presented here capture the most significant and relevant of the various drivers of change, present them in plausible combinations, and between them capture the range of possible outcomes. They should be used as the basis for discussion - they are designed to shape and structure the NMC's debate over the future of pre-registration nurse education. But they are intended to be flexible, and readers are encouraged to adapt them to reflect their own understandings, using the material presented above where appropriate.

The scenarios are set in 2015 and focus on how the nursing profession in the UK has developed, setting the profession within the broader context of healthcare and policy. They consider how the following might have changed:

- Degree of specialisation and generalism (see discussion of these terms above pages 33-35)
- Development of 'advanced' roles
- Contribution of support staff
- Interface between the roles of specialist nurses and other specialized healthcare professionals

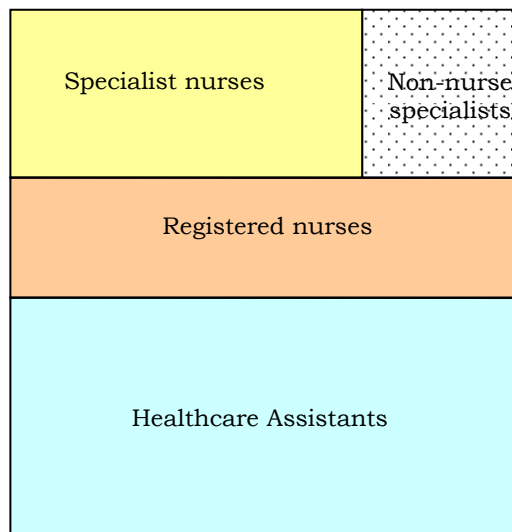
The existing 'Branches' are not mentioned specifically in any of the scenarios. The reader should decide how, or whether, they remain appropriate in each scenario.

A. Steady as she goes



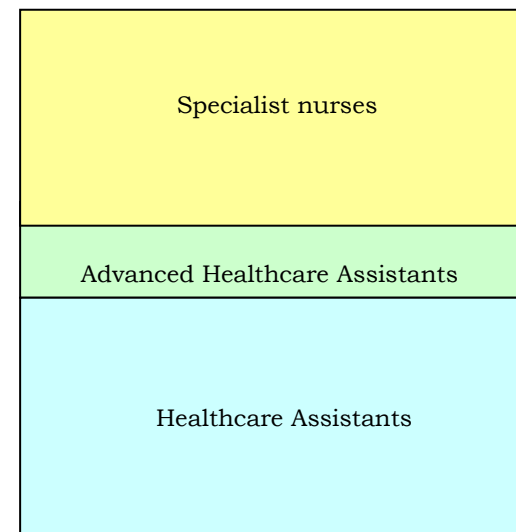
Scenario A represents minimal change from the present state in which there are currently relatively few specialist nurses working at an advanced level, in a small number of specialist areas. The majority of nurses are working in more generalist roles supported by health care assistants. There is a fairly clear and generally understood distinction between nurses' roles and those of other healthcare professionals.

B. More specialisms for all



In **Scenario B** there is increased demand for specialist staff in a wide variety of roles. Many of these are filled by nurses, but an increasing number are now carried out by other healthcare professionals. There are also fewer generalist nurse posts. As a result, there are fewer trained nurses overall than in option A. The demand for health care assistants remains fairly constant.

C. No more generalists



In **Scenario C** nursing has responded to the increasing demands for specialisation by all registered nurses becoming specialists at a more advanced level. There are many more areas of specialisation (including advanced generalist nurses) and health care assistants bridge the gap in basic nursing care. However, the growth in the number of HCAs, and the loss of generalist nurse roles, has led to a differentiation in the levels of working of health care assistants.

SCENARIO A: STEADY AS SHE GOES

For some years now the UK economy has been growing rather modestly, as global competitive pressures and the under-performance of the US economy have held back UK plc. As a result, healthcare expenditure in the UK has averaged 2% a year in real terms - or 'stand still', as the NHS calls it. The centre-left parties have continued to dominate politics in all four of the UK nations. Nationalist parties have led administrations in both Scotland and Wales, but the much-predicted rifts between them and Westminster have failed to materialise. Politics in Northern Ireland now seem more and more to resemble those in the rest of the UK. Meanwhile, in London, there is much talk of the Prime Minister beating Tony Blair's ten year term if he wins next year's general election- although Labour's lead over the Tories narrows with each by-election.

*Below trend economic growth
Restricted health expenditure
Centre-left politics*

Harmonious relationships between UK nations

The public remains broadly supportive of the NHS, despite news stories which seems to alternate between the latest drug which the NHS cannot afford and accounts of the latest medical blunder. In general, people in Wales, Scotland and Northern Ireland report greater satisfaction with the NHS than do those in England - a pattern which is repeated across all the public services. There is still discontent in England at the 'lavish' financial settlement for the devolved countries, which the Conservatives have promised to review if they win the next election. National guidance on cost-effective drugs and procedures continues to attract controversy, especially when Scottish and Northern Irish patients are given treatments which are rationed in England and Wales.

NHS remains generally popular

English concern at inequalities in healthcare

'Rationing' decisions are controversial

Acute healthcare has undergone some major re-configuration, particularly in the past two years. After seemingly endless battles to 'save our hospital', communities up and down the country are now more willing to accept that the new patterns of care - more services closer to home, some specialist services more centralised - really can work. But there is still a lot of scepticism, and some parts of the UK still refuse to countenance change from the old DGH-based model, as rows over NHS funding lead many to believe that the proposed changes are just 'cuts'. Long-term care continues to develop, albeit slowly, with more and more examples of integrated services addressing the medical and social needs of people with chronic conditions and their

Some progress on Healthcare re-configuration

Slow progress on long-term care

families. Most NHS patient record systems now 'talk' to each other, and there are some promising pilot schemes for patient-held records on smart cards.

ICT starting to impact on patient care

Health policy in each of the UK nations continues to emphasise the importance of health promotion. Attempts to address the complex causes of health inequalities still drive much government effort, although success seems illusive. Many people in their 'third age' are increasingly adopting healthier lifestyles and spending ever-larger portions of their income on exercise, diet and complementary approaches of various sorts, but poorer people and those in the younger generations are not so easily engaged. As a result, the burden of long-term conditions continues to increase, albeit at a slightly lower rate. Carers complain that their needs are still not being met, despite everyone praising them for the dedication and saying that the NHS would collapse without them.

Emphasis on health promotion

Inequalities remain

*Burden of disease increases more slowly
Carers neglected*

Patient choice as a mantra for the NHS has become somewhat discredited, especially outside England. Once waiting lists were conquered the focus shifted increasingly to long-term conditions, and there the notion of 'choice' seemed to have less currency, with many fewer providers in most part of the country. The private sector continues to operate successfully in many areas of acute care, especially in England, and it forms one of several 'benchmarks' which are used to drive up efficiency and performance throughout the UK. The four nations continue to experiment with different forms of regulation, each taking its own route. Each nation is still struggling to coordinate the various elements, and to find a cost-effective balance between risk reduction and innovation. Relationships between the NHS and local government remain rather difficult, and the third (non-statutory) sector complains bitterly of its second-class status.

Patient choice no longer a panacea

Private sector still has major role in England

*Healthcare regulation struggling
Local govt and 3rd sector relations strained*

The healthcare professions continue to evolve in response to their changing environment, developing some new roles and acquiring some new specialisms, in a fairly uncoordinated way, largely in response to local needs. There is some competition for 'turf' between the professions. Nationally, the healthcare professions complain of over-regulation, with the government unsure about the role of the employer and therefore trying to develop UK-wide regulatory regimes which embrace not only the professions but also all support workers. Recent

Uncoordinated development of new roles

'Over-regulation' of the professions

scandals appear to have shaken the government's confidence that risks are being effectively managed, and Scotland, N Ireland and Wales are now publicly expressing their disquiet at what they see as a heavy-handed, one-size-fits-all approach.

The nursing profession continues with only marginal changes. The total number of nurses has increased slightly over the past 10 years, in line with expenditure on healthcare, with the biggest growth areas being in care of the older person, and in the community. Workforce planning has not managed to match supply and demand over the period, with a sharp cut-back in training at the end of the last decade, and more recently an expansion. The profession has been subjected to the same regulatory pressures as the others. Nurses have assumed more specialised and more advanced roles almost on an opportunistic basis, responding to local circumstances. Perhaps as a result, there is little uniformity over job titles or levels of qualification required for particular roles. Discussions continue about the best mix of qualified and unqualified staff in nursing, and in some cases nurses suspect the balance has been shifted simply to save money.

Strategic planning of advanced roles remains fragmented with many posts being established on a fixed term basis following small financial injections of funds for development. There is little evaluation of new roles as many are not in place long enough to demonstrate achievement. Advanced and specialist nurses are becoming increasingly frustrated with low levels of support and understanding of their roles within their own profession and in the wider healthcare arena. They are becoming overworked as there is no-one to take over their clinical responsibilities when they are on leave, and have little opportunity for study leave. Many are becoming so specialised there is limited availability of supervision for professional development. Although advanced practice is registered, the proliferation of titles and transitory nature of posts makes consistency difficult, with a lack of clarity as to which roles are advanced and which not. In the wider profession there is a growing feeling that nursing should return to core values of caring and that there is a need to reestablish a clear nursing identity.

Slight increase in nurses

Supply of nurses not meeting demand

Some new roles for nurses, but uncoordinated

Skill mix debate sometimes driven by cost

*Little evaluation of new roles
Advanced and specialist nurses feel isolated*

Many nurses feel the profession has lost its way

SCENARIO B: MORE SPECIALISMS FOR ALL

Gordon Brown's defeat in the 2012 general election was not really a surprise. Despite all the excitement over the Olympics, his government looked and sounded tired, and people wanted a change. The Conservative administration introduced a raft of centre-right policies, which had two immediate effects on the NHS. In England, health policy changed - more emphasis on the private sector and co-payment, a 'tougher' line on NHS performance; in the rest of the UK, where the Tories were still in a minority, tensions between the three smaller nations and England grew. Partly this was rhetorical - old loyalties and hatreds could now be given free reign - and partly substantive - the emphasis on public-private cooperation in health was viewed with much more suspicion than it had been under Labour's direction. There was also now much more interest in establishing regional government in those parts of England which felt that they were not sharing the prosperity and values of the South East. But despite all the rhetoric, health care expenditure in England - as in the rest of the UK - actually continued to rise in line with the long-term trend in the years 2010-15, and those in the NHS felt that, despite the pressures for greater efficiency, there was actually some new money for new developments.

Centre-right politics in England

Tensions between the UK nations

Interest in English regional govt

Health spending – public and private - increasing

Public perceptions of the NHS both reflect and shape the political agenda. In England, the mood has shifted perceptibly, with more people now willing to contemplate spending their disposable income on main-stream healthcare - most dental care is now private, and there is a small but rapidly expanding supply of private domiciliary nursing, midwifery services and physiotherapy, speech and language therapy and psychotherapy. Many people lament the performance of the NHS, focusing on lack of choice and professional arrogance, and the highly-publicised decisions on which new therapies will *not* be funded, rather than the evidence of improved performance (negligible waiting times, improved survival rates). In northern England and the rest of the UK, private healthcare is still a very marginal activity. Here too people complain about the NHS, but still with great fondness. Each nation is now very explicit about its differences in healthcare policy, and the comparisons between what different countries offer different groups of patients is highly politicised. English tax payers perceive they are subsidising the rest, and this is now a hot political issue.

More interest in private healthcare in England – more private options

NHS viewed as too professionally dominated, and rationed

Rest of the UK loyal to NHS

Each nation is still committed in theory to re-structuring healthcare, providing more locally, but with some specialised services more centralised. But progress has been patchy - large urban areas have tended to accept the model more readily than semi-urban and rural ones. Where there has been strong political leadership and substantial pump-priming of the new model, public opinion has gradually been won over; but in many parts of England, all government policy on health is viewed with suspicion. Progress on long-term care has been greater. Each nation has made this a priority, and many patients with long-term conditions and their families now tend to receive well-integrated services. In England, there has been a flurry of activity in developing new models of care which give much greater roles to the voluntary and commercial sectors, and recent government guidance in England has now indicated that the preferred model is one in which the voluntary or commercial sector coordinates and commissions the care on behalf of the patient and family. NHS information and communication technology has developed gradually, and most systems now talk to each other. Several innovative projects have been funded in England with the express aim of using ICT to give the patient control over their care.

Progress patchy on healthcare re-structuring

Progress on long-term care

Greater role for voluntary and private providers

ICT development gradual

There is consensus throughout the UK that health promotion is a key priority for the future, although political disagreement about how best this can be achieved. Progress has been encouraging, with several indicators of long-term health heading in the right direction as a result of changes in personal lifestyle, and - especially outside England - a plethora of community and workplace-based initiatives. Health inequalities remain stubbornly high, though, and there is still real concern that improvements in public health will not be sufficient to off-set the effects of an ageing population. Much remains to be done.

Health promotion a priority, with some success

Inequalities remain

The regulation of healthcare is another area of tension between the nations. Scotland, Wales and Northern Ireland reject the English approach, which relies upon a mixture of public-private competition and ruthless punishment of poor performance. Instead, they favour a more consensual approach, and tireless encouragement of joint working and confidential inspection. There is greater agreement over the regulation of the healthcare professions, though, which remains a function reserved to Westminster. Opinion has swung

Differences over healthcare regulation

on this issue over the years, but now employers are being given an increasingly central role, as statutory regulation is perceived as being unresponsive, ponderous and too remote from practice. Relations between the NHS and local government remain rather difficult, but there has been strong interest throughout the UK in the development of social enterprise as a better way of delivering some aspects of care. On the left, it is seen as a way of building social capital; for the right, it is a way of undermining the power of the bureaucrats. The growing number of carers still believes that the support available to them is totally inadequate. With the exception of the few who use the new tax breaks to purchase support, most carers feel trapped - they want to care for their elderly relatives, and know that their bargaining position with the NHS and Social Services is weak.

*Lighter-touch
regulation of the
professions
Local govt relations
difficult
Growth of social
enterprise*

*Most carers feel
exploited, despite tax
breaks*

Nurses have responded to these changes by increasingly adopting more specialised roles, to meet public expectations and the demands of ever more technological healthcare. Other professionals are doing the same, and specialised roles in aspects of diagnosis and treatment are also being taken by laboratory scientists, radiographers, physiotherapists and others. A small but increasing number of junior doctors from eastern Europe is also happy to fill these roles for a few years early in their careers. Many younger nurses are now setting themselves up in social or commercial enterprises to meet the growing demand for care in the community, and are successfully negotiating contracts with the NHS. Alongside the development of 'narrow' specialisms there is also much interest in the role of 'specialist generalist'- a nurse with advanced skills and knowledge who coordinates the care of patients, especially in care of the elderly and paediatrics. Such staff are seen as cheaper and more flexible alternatives to junior and middle grade doctors, who will view such a role as their career choice, rather than a stepping stone to something better.

*More specialist roles
for nurses and others*

*Nurses working for
themselves*

'Specialist generalist'

Nursing career pathways are many and varied with nurses themselves carving their own careers in a more entrepreneurial environment. New and innovative approaches to health and social care are being developed. Interdisciplinary consortia of health care professions are establishing new services and there is little consistency across regions of the type of services that are available. Some people, who are able, are travelling long distances to avail themselves of particular types of service, whereas others have limited

*Varied career
pathways*

*Interdisciplinary
consortia*

options. Boundaries across sectors are breaking down to provide more holistic approaches to care, making regulation more difficult particularly in the growing private sector. Identifying competencies for newly developed and often unique roles is challenging. Nursing is losing its identity and titles often do not include 'nursing'. Users and professionals often are unaware of the levels of working or the standards to be expected. Again there is little evaluation of newly developing packages of care and users assess services mainly by word of mouth and based on personalities. Education is taking on a more interdisciplinary approach at both pre and post registration levels.

*Regulation of new
roles difficult*

*Little evaluation of
new roles
More inter-
disciplinary education*

SCENARIO C: NO MORE GENERALISTS

The NHS has seldom had it so good! As the UK economy has continued to expand at above-trend rates, there has now been significant real terms growth in NHS funding for most of the past 12 years, with just a 3-year dip to long-term growth rates in the years around 2008-10. UK health spending is now comfortably towards the top of the international league table, and it shows - most NHS buildings are modern or re-furbished, pay rates are competitive, there are lots of new initiatives. This growth has sustained centre-left political parties in government throughout the UK, and as a result the growth money for healthcare has all ended up in the NHS. However, the public do not appear convinced that their NHS has 'never had it so good'. Media coverage focuses mainly on the latest scandal or therapy denied by the PCJEBHC (Permanent Citizens Jury on Evidence-Based Healthcare - the rather inelegantly-named third successor body to NICE), and ignores the successes. But nevertheless, private healthcare has failed to expand, and most people seem to be able to get care of good quality when they need it. Postcode lotteries persist in some fields, and the difference between the four nations are still controversial, but there is still a prevailing left-of-centre consensus in the UK.

Sustained growth in health budgets

Centre-left govt and dominance of the NHS

Public concerns remain

Local variation in delivery

The biggest impact of this period of sustained expansion has been the massive re-structuring of healthcare. In 2011, the four nations chose the 50th anniversary of Enoch Powell's *Hospital Plan*, which had shaped hospital care for two generations, to launch a new vision, which attracted cross-party support. Called *Nearer and Better*, it consolidated many of the changes which were already in chain and provided 4 years of dedicated resources to developing a comprehensive network of community teams, modern local hospitals, and a world-class centre of excellence in each English region, three in London, two in Scotland and one each in Wales and N Ireland. The three-years of quiet preparation which went into *Nearer and Better* paid off, as the politicians, professionals, managers and commentariat all eventually signed up, and the sustained investment and high-level commitment has now resulted in what the independent commission charged with implementing it has formally declared to be 92% completion. The final 8% is programmed for the coming year. Progress has also been good in the supporting ICT infrastructure, with patient records now instantly available to all professionals not only in the NHS but also in many Social Service departments and relevant voluntary agencies.

Massive re-structuring of healthcare

ICT well developed

Progress in long-term care has perhaps been somewhat more modest, but is nevertheless significant. Most people with a long-term condition can now expect to have a key worker with the resources and authority to commission what that individual and their family needs, from whatever source is most appropriate. In practice, there are still some problems though - for example, services are not always available to be commissioned, the nationally-directed packages of care do not really meet the needs of carers, and many criticise the dominance of healthcare professionals and the medical model in the provision of services.

Modest progress in long term care

There is general recognition that health promotion remains key to the future sustainability of *Nearer and Better*, and progress has been stubbornly slow. While many indicators of life-style and health status have at least stabilised, and some have improved, large sections of the population seem immune to the message. It has been difficult to engage with many young people, whose substance misuse and rates of sexually transmitted infections are actually increasing, and some of the minority ethnic communities (long-established and new, from the Accession States). There has been a focus on tackling health inequalities as the way to promote population health in each nation, but many of the structural changes which have been attempted seem to have had little effect.

Inadequate progress in health promotion

Excluded groups

Patient choice, within the limitations of the NHS and national determination of evidence-based practice, is a common theme of health policy. It is often interpreted as being a professionally-mediated process, and collective voices are often valued above those of individuals, but patient groups are generally supportive of the approach being followed. Those looking for a more 'consumer' model, however, with the option to use state resources in the private or voluntary sectors, are disappointed.

Limited patient choice

In commissioning and the regulation of healthcare there has been a determined move towards decentralisation in each nation. This is implicit in the philosophy behind - and part of the price paid for gaining consensus on - *Nearer and Better*. Different models of provision have sprung up as a result, and the setting and monitoring of

Decentralisation of commissioning and regulation leads to diversity

standards is now primarily a local or regional function, within national guidelines. The creation of the NHS Board of Governors in England in 2011 has helped to insulate Ministers from the consequences of this policy, although this comes under strain as the general election approaches. The regulation of the professions is also delegated wherever possible to employers and local commissioners, and there is a general recognition that 'less is better'. The voluntary and for-profit sectors (with the exception of a small group of well-connected organisations) generally feel marginalised and unable to realise their potential. Local government still feels somewhat excluded too, although there is growing interest in Scotland and Wales in looking at the merger of certain aspects of community health services and personal social services, under a local government umbrella.

*Political independence for NHS
Professions regulation 'light touch'
3rd sector feels excluded
Experiments in merging health and local govt*

The days of the generalist nurse are over. The influence of the professions and certain 'cutting edge' practitioners on the implementation of *Nearer and Better* is obvious in the growing value attached to specialisation, both in the highly specialist hospitals and in the local and community settings. Patients and professionals alike seem to believe that the best quality care can only be delivered by staff with a narrow specialism. Nurses have defended their territory effectively, and the result is that almost all nurses - with the exception of an increasingly anachronistic group of older nurses - are now striving to obtain recognition in advanced practice with a small group of patients. To meet the cost implications of this, the total number of nurses has gradually decline, and the NHS has filled the gap by recruiting more and more healthcare assistants. This latter group is expected to take on more and more complex roles, so to meet safety concerns, and to assuage their own career aspirations, a new cadre of 'Advanced' Healthcare Assistant is rapidly emerging.

No more generalist nurses

Many nurse specialists

Expansion in HCAs

Advanced HCAs

Career pathways have become increasingly more structured and educational preparation standardised across a range of nursing titles that represent the level of practice and degree of specialisation. There are moves to open further parts of the register for particular branches of nursing, and proposals to include adding Advanced Healthcare Assistants to the register. There are also moves to provide educational packages to make the transition from Advanced HCA to registered nurse. This is a result of growing unrest amongst Advanced HCAs at the elitist attitude of registered nurses. Nursing identities are taking on a more

Standardised career pathways for nurse specialists

Advanced HCAs on the Register

technological ethos and, although there remains significant patient contact, critics argue that nurses are losing their caring approach. They are accused by many of being 'mini doctors'. However, many patients prefer to see the specialist nurses rather than doctors and are highly satisfied with the service they receive, as they feel that the new nurse represents the best of both worlds. The majority of registered nurses are educated to degree level, with many having masters or doctorates. They are taking significant roles in teaching and also research, with a growing body of nursing research, which is improving in quality and impact.

Nurses as 'mini doctors' – popular with patients

High levels of qualification

CONCLUSIONS

This paper has provided a summary of the likely key drivers of change in healthcare and policy, nursing and nurse education in the period to 2015. All of these factors are clearly inter-related, and almost every issue discussed here is subject to uncertainty. The Scenarios in the previous section suggest just some of the possible combinations, in a way which is designed to help readers to create their own realistic scenarios, drawing on the evidence assembled.

We hope that the reader will do this, to tailor the scenarios to their particular interests. Also, scenario construction can be a useful learning tool – it is often in the manipulation of the data and the construction of the scenario that one gets a better understanding of the nature of the drivers and the dynamics of the system.

The three scenarios here are based on outcomes for nursing, but each makes different assumptions along the way for a variety of different drivers, and these can be used by the reader as a 'check list' when compiling their own: the economy; health expenditure (NHS and private); politics and devolution; public view of healthcare; rationing and commissioning; location of care; long term care; information and ICT; health promotion and disease prevention; choice/patient information; competition and regulation; regulation of healthcare professions; non-NHS provision (local government, 3rd sector, commercial); carers; nurses: generalism versus specialism; nursing: advanced versus basic; nursing: relationship with support staff; professions other than nursing.

So what can we conclude about the likely direction of healthcare and policy, nursing and nurse education in the UK during the coming eight years? As in any attempt to consider the future, there is no one answer, and there is lots of uncertainty. We would be unwise to make many firm predictions, but we can see that some outcomes are more likely than others, and certain constant features will remain.

In our original report for the UKCC in 1998, *Healthcare Futures 2010*, we concluded with a set of paradoxes for the future, as a way of capturing this complexity and uncertainty. This attracted a lot of interest at the time, and seems to have currency still today. So we finish with a new set of paradoxes, which summarise many of the issues raised in this paper, and which interestingly are quite similar to those set out nine years ago...

Healthcare in the future, therefore, will be characterised by a series of enduring paradoxes:

A Paradoxical Future

More money	...AND...	Gap between supply and demand
Diversity between UK nations	...AND...	Commonality of constraints
Emphasis on prevention	...AND...	Big demand for cure and palliation
Continued dominance of the hospital	...AND...	Policy drive for care closer to home
Big demand for high-tech medicine	...AND...	Interest in complementary approaches
Public reliance on professionals	...AND...	Greater lay assertiveness
More well-educated, well-informed and confident patients	...AND...	Many patients lacking information and confidence
Demand for high technical competence and 'scientific rationality' in nurses	...AND...	Continuing need for 'human' qualities and the time to express them
Blurring of professional boundaries	...AND...	Separate professional traditions, organisations and public expectations
More disease of old age	...AND...	Demands by younger tax-payers
Continuation of old moral certainties	...AND...	Moral uncertainty in new environments
The public will expect nurses not to change	...AND...	Nurses will demand new roles and responsibilities