

*Quality with Compassion:
the future of nursing
education*



**Report of the Willis Commission
2012**

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Introduction from Lord Willis



Health professionals in the 21st century work in multidisciplinary teams to improve the quality of care and health outcomes. If patient-centred care in acute and community settings is to become the norm, as the Briggs report recommended 40 years ago, the nurse must be a professional among equals, and be seen as one, not a handmaiden to other professionals (Committee on Nursing 1972). The need to produce competent, confident, critical-thinking nurses with the ability to lead, to question and to be questioned should be at the heart of modern pre-registration education programmes.

Given the concerns expressed about the modern nursing profession in many sections of the media, the decision by the Royal College of Nursing (RCN) to establish an independent commission to examine the 'health' of pre-registration nursing education was a courageous one. The RCN is to be applauded – few professions enjoy the public standing of nursing and any challenge to that standing should be addressed.

It was my privilege to be entrusted to chair the Willis Commission, with the freedom to take evidence from the widest possible group of stakeholders, including patients. I would like to thank the commissioners, expert reviewers and advisers, who gave their time generously to help prepare this report in such a short timescale. I must also pay tribute to the significant number of organizations and individuals who contributed written and oral submissions, demonstrating passion and commitment to getting nursing education right.

Our brief was straightforward and focused:

What essential features of pre-registration nursing education in the UK, and what types of support for newly registered practitioners, are needed to create and maintain a workforce of competent, compassionate nurses fit to deliver future health and social care services?

It was neither new nor novel. Countless inquiries and reports have been conducted over many decades seeking ways to improve nursing education and training. Sadly, although many of the recommendations have been blindingly obvious, there has been insufficient political or professional will to implement them fully. I hope that will not be the fate of this report.

We found the case for moving to an all-graduate nursing profession not simply desirable, but essential. Indeed we found it totally illogical to claim that by increasing the intellectual requirements for nursing, essential for professional responsibilities such as prescribing, recruits will be less caring or compassionate. Such accusations are seldom made against other all-graduate professions such as medicine, midwifery or

physiotherapy, and there is absolutely no evidence to support them in nursing.

The roles of tomorrow's nurses will be even more demanding and specialised, and will require even greater reserves of self-determination and leadership as health care moves into a myriad of settings outside hospital. Our education system must produce nurses who have both intellect and compassion, not one or the other.

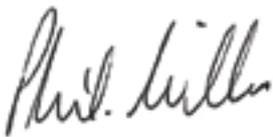
The foundations of high quality modern nursing education are already in place. The new Nursing and Midwifery Council (NMC) standards command widespread support, and universities have responded well to develop curriculums that reflect changing patterns of care. Service users and their representatives should, however, be more closely involved in both recruitment and education, as modern nursing must focus primarily on them as individuals and not simply on treating conditions.

Neither is the requirement to put evidence-based care at the heart of nursing education fully met as yet. Nursing scholarship is relatively new and research must play a more significant role in determining best practice. Encouraging nurses to question practice constantly and look for evidence to improve performance will improve patient outcomes. Research must not be seen as an optional extra for the sake of a graduate programme. To encourage this vital part of the education process, greater attention must be paid to the next generation of nursing academics and facilitating their work in both academic and clinical settings.

The commission was also struck by the persuasive argument that the pre-registration programme provides the basis on which to build a lifelong nursing career. The notion that nurses can be educated in a

silo, and that following registration they are the finished article, could not be further from the truth. This is why high quality mentorship, preceptorship and continuing professional development are crucial to improving patient outcomes. Nursing education thrives when all staff, from medics to healthcare assistants, are constantly having their skills refreshed and updated – including the development of teamwork. We hope that policy-makers, employers, universities and professional bodies recognise and act on this challenge.

Finally, we have been both humbled and excited by the enormous dedication, intellect, compassion and altruism that shone through the many submissions and presentations. Indeed the message was the same wherever the commission took evidence throughout the UK – the desire to provide tomorrow's nurses with the very best opportunities to offer the very best care. Nowhere was this more apparent than when we met nursing students, whose ability to articulate their ambitions and their desire to nurse was awe-inspiring. Valuing what students bring to their education is crucial: they are the leaders of tomorrow and it is their voices that must be heard.



Lord Willis of Knaresborough
Commission chairman

Acronyms used in this report

CPD	Continuing professional development
CQC	Care Quality Commission
EU	European Union
HCA	Healthcare assistant
HEE	Health Education England
HEFCE	Higher Education Funding Council for England
HEI	Higher education institution
IPE	Interprofessional education
LETB	Local education and training board
MPET	Multiprofessional education and training levy
HCSW	Healthcare support worker
NHS	National Health Service
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
NMC	Nursing and Midwifery Council
NMET	Non-medical education and training levy
NQN	Newly qualified nurse
NVQ	National vocational qualification
OU	Open University
RCN	Royal College of Nursing
RN	Registered nurse
SHA	Strategic health authority
SIFT	Service increment for teaching
SVQ	Scottish vocational qualification
UKCC	UK Central Council for Nursing, Midwifery and Health Visiting
WHO	World Health Organization

All quotations in italics in this report are taken from written and oral evidence submitted to the commission.

Summary

Patient-centred care should be the golden thread that runs through all pre-registration nursing education and continuing professional development. The focus must be on helping service users, carers and families to manage their own conditions and maintain their health across the whole patient pathway. Involving service users and carers as much as possible in recruitment, programme design and delivery is a key way of achieving this.

The commission did not find any major shortcomings in nursing education that could be held directly responsible for poor practice or the perceived decline in standards of care. Nor did it find any evidence that degree-level registration was damaging to patient care. On the contrary, graduate nurses have played and will continue to play a key role in driving up standards and preparing a nursing workforce fit for the future.

Nurses and their organizations must stand up to be counted, to restore professional pride and provide leadership and solutions to the challenges of poor care and a decline in public confidence. Their influence on the next generation of nurses is crucial at this critical moment in the profession's history.

Nursing education should foster this strong emphasis on professionalism. It includes embedding a caring professionalism that has patient safety as its top priority, and respects the dignity and values of service users and carers. It requires a constant commitment to quality, with a willingness to engage with and help extend the evidence base for practice, and to develop reflective practice and critical judgement.

Nursing education programmes must be better evaluated, and based on extensive research that provides evidence on the correlations between current practice, entry criteria and

selection processes, attrition rates and course outcomes. Rigorous research on curriculum evaluation at the micro and macro level should investigate content, process and outcome.

Our future healthcare system will require graduate nurses to practise and lead nursing and healthcare teams in a variety of roles, providing care in many settings. There should be a diversity of entry points and career pathways into nursing.

High quality recruitment campaigns should be targeted at all potential nurses, including graduates of other professions, healthcare assistants and mature people as well as school-leavers, to encourage the best possible range of applicants and ensure they have the potential to develop the right combination of critical judgment, practical skills and values.

Service providers in and beyond the National Health Service (NHS) must be full partners in nursing education, and recognise that the culture of the workplace is a crucial determinant of its success and a learning environment for all staff. Their boards must be able to demonstrate that they pay full attention to education issues.

Universities should fully value nursing as a practice and research discipline and recognize its contribution to their community engagement. Vice chancellors should work with nursing deans to develop a collective narrative about and commitment to the rightful place of nursing in universities.

Sustained attention should be paid at national as well as regional and local levels to developing a strategic understanding of the nursing workforce as a whole and as a UK-wide resource. Workforce planning and the commissioning of education places must be conducted in effective local and national strategic partnerships between planners

and providers of health care and education within and outside the NHS.

This work must be based on robust evidence-based planning. A consistent data set should be created and maintained across all four UK countries that includes information from all sectors on nurses and healthcare support workers. Short-term measures that may create future shortages should be avoided.

Part 1: Introduction

Part 1 describes why and how the commission was set up and went about its work. The focus here is on its scope and purpose, and how it achieved its objectives. The outcomes of the work will be discussed later in this report.

1.1 Why the commission was established

‘Nursing is a demanding yet rewarding profession that asks a lot of its workers. We are privileged to have such a dedicated and committed nursing workforce in the UK. Nursing is an incredibly self-aware profession, constantly striving to improve and give patients the best possible care. It is imperative that nurses are provided with the right education and skills to equip them for their roles’ – Lord Willis of Knaresborough, commission chairman

The United Kingdom needs a nursing workforce equipped to help meet the complex healthcare challenges of today and tomorrow, to provide care and support in times of illness and distress, and to help people stay healthy. How this workforce is educated is therefore a matter of great importance.

High quality education for its own sake confers huge benefits on society and the individual, but pre-registration nursing education is not an end in itself: its primary purpose is to prepare the future nursing workforce. Nursing education must therefore be driven by decisions and predictions about what future health services could and should be like, and what knowledge and skills nurses will need to meet individual and population needs.

These needs are widely recognised. The major factors affecting the health of the population and of individual people include the following (Prime

Minister’s Commission on the Future of Nursing and Midwifery in England 2010):

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

Many of these trends underline not only the need to scale up efforts to promote health and prevent illness, but also the huge and growing need for skilled care for people with long-term conditions and addictions, the complex needs of ageing, vulnerable groups, the early years, and many others. People are living longer and often have a mix of illnesses and disabilities that require skilled support, management and treatment.

Meeting these needs in cost-effective ways that match people’s preferences requires major shifts of focus, not least in professional attitudes and expertise, as well as closer collaboration and integration between health, social care and other sectors, and different professions. Current policy proposes that the system should be better integrated around service users, their carers and families. It should provide better support for self-care, and deliver more care closer to home, from the cradle to the grave.

This means service users and carers should be integral members of their care team. They will be increasingly likely to hold a personal health budget and should be fully involved in planning their care and making decisions if they so choose. Good health will result from ‘co-production’ – professionals sharing skills and

knowledge to help service users achieve the best health possible.

Box 1: A note on terminology

This report generally uses the term ‘service user’ to describe any health and social care service user who requires the professional services of a nurse for health promotion, illness prevention, care or treatment. ‘Service users’ comprise hospital patients, clients, care home residents, and all similar categories.

We follow the Institute of Medicine definition of patient-centred care: ‘care that is respectful of and responsive to individual preferences, needs, and values, and ensuring that patient values guide all clinical decisions’. It encompasses all aspects of how services are delivered in all settings, including compassion, empathy and responsiveness to needs, values and expressed preferences, and involvement of family and friends (King’s Fund 2011).

The term ‘nurse’ refers exclusively to people registered as nurses with the NMC. It does not include healthcare support workers, a generic term for non-registered staff who often work under nurses’ supervision to deliver direct patient care.

Nurses work in the NHS and for many other health-related organizations. We use the term ‘health system’ to mean the sum total of all the organizations, institutions and resources in the UK whose primary purpose is to improve health and provide end-of-life care.

‘When they are at their most vulnerable, patients rely on caring, compassionate and well-educated, competent nurses to ensure they receive the care they need. Preparing nurses for this essential role is a top priority. The curriculum must reflect the needs of patients and be immediately relevant and applicable to the central role of nurses: caring for patients’ – Patients Association

Patient-centred care, as the foundation of good nursing, is enshrined in the code produced by the Nursing and Midwifery Council (NMC), the professions’ regulator (NMC 2008a). All nurses are required to uphold the code, which says, *‘Make the care of people your first concern, treating them as individuals and respecting their dignity.’* It is also central to the NHS Constitution, which sets out the

rights of patients and the public, and promotes values such as respect, compassion and commitment to quality of care (Department of Health 2012a).

Despite these good intentions, stories of unsafe, poor and heartless care are heard daily, in the media, at professional conferences and in everyday conversations. To take one prominent example, nurses neglected and humiliated patients at Stafford Hospital, where death rates were significantly higher than average (Mid Staffordshire NHS Foundation Trust Inquiry 2010). These deaths were attributable to systemic as well as individual failures. The inquiry found that the culture of the trust was not conducive to providing good care for patients or providing a supportive working environment for staff; problems included bullying and low morale.

As other stories of appalling care and mismanagement unfold, questions are being asked about the quality of pre-registration nursing education and the competence of newly qualified nursing graduates. Some critics blame the problems explicitly on the move to degree-level nursing education. The fitness for purpose of nursing education is once again under scrutiny, at a time when it is already in the middle of a far-reaching improvement process.

Patient-centred care is not just a matter of personal qualities such as being kind, but depends on many factors including working in a positive practice setting; having the right number and mix of staff with the right skills, knowledge and attitudes; and supporting, educating and developing staff. To acquire those skills, knowledge and attitudes, patient-centred care

Figure 1: The dynamic context of nursing education
(Source: WHO 2003)



must also be the foundation of good nursing education.

Nursing education, like the quality of care, cannot be fully understood in a vacuum or as a stand-alone phenomenon. As conceptualised by the World Health Organization, it operates in a dynamic, ever-changing context and is itself continually changing (Figure 1, adapted from WHO 2003). This understanding led the commission to consider the wide range of issues outlined in this report. As in the figure, patient-centred nursing practice was the 'golden thread' that it followed throughout.

To explore these questions and challenges, and help ensure the future nursing workforce is fit for purpose, the Royal College of Nursing (RCN) – the UK's leading professional association and trade union for nursing – invited Lord Willis of Knaresborough to chair an independent commission on nursing education.

1.2 Terms of reference

'We know that the vast majority of nurses deliver excellent care. However, rather than refuse to accept that there may be issues in some areas, the RCN asked Lord Willis to look at the form and content of education and preparation needed to provide a nursing workforce that is fit for the future. The work of the commission comes as the RCN considers how the profession can meet future healthcare challenges' – Peter Carter, chief executive and general secretary, RCN

The Willis Commission on Nursing Education was launched on April 25, 2012 with coverage in the national and healthcare media. Hosted and funded by the RCN, the commission worked independently.

Its work feeds into the *This is nursing* project sponsored by the RCN's Nursing Practice and Policy Committee.

The commission's independence was assured by the appointment of Lord Willis as chairman and a panel of seven experts from across the UK, comprising service user representatives, nurse educationists, managers and practitioners. It was supported by special advisers, and a secretariat comprising RCN staff on secondment and an independent consultant (Appendix 1).

The commission considered the following question:

What essential features of pre-registration nursing education in the UK, and what types of support for newly registered practitioners, are needed to create and maintain a workforce of competent, compassionate nurses fit to deliver future health and social care services?

The commission wanted to determine what excellent nursing education should look like and how it should be delivered, identifying good practice and sharing information. It paid attention to the legal and operational framework of nursing education, including the potential impact of its recommendations on the independent sector. It was also mindful of the wider goals of developing relationships with future service providers, and achieving financial sustainability.

Its recommendations should provide an impetus for real change by addressing the following challenges:

- Help policy-makers to determine what human and financial resources for pre-registration nursing education are needed to produce a nursing workforce fit for the future.

- Help education providers and commissioners to remove or minimise the barriers to best practice in pre-registration nursing education.
- Identify suitable practice learning experiences that provide effective supervision and support for nursing students.
- Help the employers of newly registered nurses to provide appropriate support, including preceptorship.
- Promote an accurate and positive public image of pre-registration nursing education.

The commission did not start out with pre-formed ideas or assumptions. It was also mindful of the new NMC standards for pre-registration nursing education (NMC 2010a). The huge challenge of implementing them is well under way, but has by no means bedded down, and they will not be incorporated in all programmes until 2013.

Opportunities to test them and evaluate their impact are limited until the first nurses graduate from the new programmes over the next few years. Nevertheless the commission hopes that its findings will help to shape the progress and effectiveness of the reforms.

1.3 The commission's programme of work

The commission's extensive and busy programme of work spanned the summer and autumn of 2012. Web pages and email addresses were created to facilitate communication with the commission, initially hosted on the RCN website and then on an independent website (www.williscommission.org.uk).

At the commission's request, a review of the UK literature on pre-registration nursing education published from 2010 to early 2012 was carried out. The major databases were searched using broad search terms, and 52 relevant articles were reviewed on numerous topics, reflecting many challenges and improvements in nursing education. Many related to programmes delivered before the 2010 NMC standards were introduced. Reviews were also conducted on leadership, mentorship and preceptorship. These background papers are listed in Appendix 2.

Lord Willis and the panel were also keen to engage with stakeholders. Individual letters were sent to around 200 organizations requesting short written submissions and background materials. Over 80 responses were received within the deadline from a wide range of stakeholders including NHS trusts and other employers, universities, professional bodies and royal colleges, regulatory bodies, patient organizations, charities and others. They included responses from England, Scotland, Wales and Northern Ireland, and others covering the whole UK.

Personal submissions from the public, professionals and students were also invited through media coverage, the websites and at events, and 43 were received from nursing students, lecturers, practising nurses, retired nurses and service users.

Following scrutiny of the technical papers and submissions by the chair, panel and independent analysts, 23 key organizations and experts were invited to give evidence during oral hearings on 12-14 June. The sessions were transcribed verbatim and checked back with witnesses to ensure accuracy. All respondents are listed in Appendix 3.

The chair, panel members and secretariat members attended and/or organised various events across the UK to publicise the commission and exchange views and information (Appendix 4). Meetings were held with stakeholders including the four UK governments' chief nurses. Lord Willis attended RCN Congress and listened to the debates, had informal meetings with nursing students, and conducted an open listening exercise.

He also undertook a series of visits across the UK, facilitated and usually hosted by panel members, where he met stakeholders and saw examples of good practice. Particular attention was paid to eliciting evidence from all four UK countries, mindful of their divergent approaches to health and nursing policy and their different histories and experiences of nursing education.

Clearly these different sources cover the gamut of types of data, from opinion and anecdote to major research studies. Due attention was paid to weighting these sources appropriately in our analysis. The full evidence can be viewed on the commission website until May 2013, after which it will be archived by the RCN for use in future work and subsequent inquiries.

A great deal of information received, while interesting and informative, was beyond the commission's remit. Much of this report is also relevant to midwifery and health visiting.

In conclusion, the commission followed a tight and demanding timescale from April to October 2012. It set itself a clear mandate, engaged with many stakeholders, and reviewed and debated a large amount of relevant evidence, including site visits to observe good practice. This report is based on the most robust evidence available, and represents the independent collective view of the chair and commissioners.

Part 2: An overview of nursing education

This chapter outlines the history of nursing education, its current position and future plans. It is discussed in the context of current far-reaching changes in the health and higher education sectors, and in the current and future nursing workforce.

Box 2: Milestones in nursing education

1860: The Nightingale Training School for Nurses opened at St Thomas' Hospital, London, establishing the pattern for professional nursing education in the UK and many other countries.

1909: The University of Minnesota bestowed the first US bachelor's degree in nursing.

1939: The Athlone report recommended that nurses should have student status.

1943: An RCN commission chaired by Lord Horder examined nursing education.

1947: The Wood Report said nursing students should have full student status and be supernumerary to ward staff during their practical training. This was not widely accepted, but the pressure to reform led to the Nurses Act, 1949.

1948: The National Health Service was founded, offering comprehensive health care for all, free at the point of delivery and funded through taxation.

1960: The University of Edinburgh launched the first bachelor's degree in nursing in the UK, and a master's degree from 1973.

1964: The Platt report from the RCN Special Committee on Nurse Education said students should not be used as cheap labour, but be financially independent from hospitals and eligible for local education authority grants.

1969: The University of Manchester offered an integrated degree programme in nursing, health visiting, district nursing and midwifery.

1971: The University of Edinburgh appointed Margaret Scott Wright to the first UK Chair of Nursing.

1972: The Briggs committee on nursing recommended changes to education and regulation. Degree preparation for nurses should increase, to 'recruit people with innovative flair and leadership qualities', and nursing should become a research-based profession.

1972: The University of Wales appointed Christine Chapman to develop the first nursing degree in Wales. In 1984 she was appointed to the first Chair of Nursing in Wales, and became the first nurse dean in the UK.

1974: The University of Manchester developed the first bachelor's nursing degree programme in England, and appointed Jean McFarlane to the first Chair of Nursing at an English university. Degree courses began at Leeds, Newcastle and London South Bank universities.

1985: The Judge report from the RCN Commission on Nursing Education recommended the transfer of

nursing education to higher education, and said students should be supernumerary.

1986: The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) launched Project 2000, a wide-ranging reform of nursing education.

1988: The WHO European nursing conference in Vienna supported degree-level nursing education and subsequently provided detailed curriculum guidance. Nursing education in many countries worldwide continued to move in this direction.

1990s: Nursing education in the UK gradually moved to higher education as Project 2000 was implemented. Delivery was mostly through the diploma route.

1997: The Nurses, Midwives and Health Visitors Act was passed, requiring the UKCC to determine the standard, kind and content of pre-registration education.

1999: The UKCC Commission for Education report, *Fitness for practice*, evaluated the results of Project 2000. It recommended a one-year common foundation programme and a two-year branch programme.

2000s: The number of graduate nurses grew steadily. Some parts of the UK moved to offering bachelor programmes only.

2001: Degree-level pre-registration nursing programmes began in Wales. All its pre-registration nursing programmes moved to degree level in 2004.

2002: The new Nursing and Midwifery Council (NMC) replaced the UKCC.

2004: *Agenda for Change* set out a new pay structure for nurses and other NHS staff that was also a rudimentary career structure.

2005: The NMC register, with its 15 sub-parts, was revised to just three parts: nurses, midwives and specialist community public health nurses.

2008: The NMC decided that the minimum academic level for all pre-registration nursing education would in future be a bachelor's degree.

2009: UK government health ministers endorsed the NMC's decision.

2010: After extensive consultation, the NMC issued new *Standards for pre-registration nursing education*.

2011: All pre-registration nursing programmes in Scotland moved to degree level only.

2013: By September, all UK pre-registration nursing programmes will be at degree level.

2020: A relevant degree will become a requirement for all nurses in leadership and specialist practice roles.

2.1 The story so far

'Caring is not for amateurs' – Florence Nightingale

Box 2 shows some milestones in the evolution of nursing education. As established by Florence Nightingale, apprenticeship was the model for professional nursing education in the UK and many other countries. Knowledge delivery, and the exposure to and delivery of nursing practice, was usually undertaken in stand-alone schools of nursing and nearby hospitals. Nursing students were pairs of hands and learned mainly from more experienced clinical colleagues. What they learned and practised often had no scientific foundation, and was often inadequate and sometimes unsafe. They had few opportunities to develop critical thinking and reflective skills, gain clinical experiences in other care settings, or learn from and conduct research.

The question of what educational level nurses need has been hotly debated ever since, often linked with explicit or implicit assumptions about the education of women and the nurse's subordinate role as the doctor's assistant. The first bachelor's degree in nursing was established over a century ago in the USA, but it was many decades before nursing was considered a suitable subject to be taught in universities in the UK, as a distinct discipline with its own knowledge base and domain of practice (Eaton 2012).

A succession of expert committees recommended moving nursing education into higher education but made little headway until the watershed of Project 2000 (UKCC 1986). This wide-ranging reform established a single level of registered nurse, with a higher education diploma as the minimum

academic level. Nursing students were to have supernumerary status.

The shift to higher education institutions (HEIs) gathered pace in the 1990s as Project 2000 was implemented. The NHS commissioned universities to deliver nursing education through time-limited contracts. The majority of nursing education has been delivered through three-year diploma programmes, with a smaller proportion of commissions for three-year degree programmes. The old training schools vanished and variations appeared across the four UK countries.

The growth of university departments of nursing was accompanied by a significant expansion in practice development, scholarship and research, and the appointment of academic leaders of nursing as professors and deans. Nurse teachers became part of an academic workforce and needed to satisfy academic and research criteria to gain promotion. Nursing research and evidence-based practice began to blossom, with a much sharper focus on patient-centred care. Many nurses embraced the new educational opportunities with enthusiasm, often taking courses in their spare time and at their own expense.

Yet there was growing disquiet that the education reforms of the 1990s failed to deliver skilled nurses for the modern healthcare system. The publication of yet another commission report, *Fitness for practice* (UKCC 1999), came at a time when the UK government and the NHS were expressing anxiety over whether newly qualified nurses were 'fit for purpose' (Kenny 2004).

Such anxieties persist, as reflected in the establishment of this commission. Yet little if any robust evidence was found to justify the concerns: as the Peach report said, *'While misgivings may exist*

2.2 Nursing education today

‘To meet public expectations, and give care that is safe and effective, nursing practice must be based on evidence, knowledge, and analytical and problem-solving skills’ – NMC

Degree-level registration is already the norm in Scotland, Wales and Northern Ireland. By September 2013 only degree-level pre-registration nursing programmes will be offered in the UK. This is the biggest change in nursing education for many years.

All programmes must now lead to a degree-level qualification, so that every successful candidate will gain a first degree in nursing, and be eligible to apply to join the NMC register. All programmes must be approved and running against the new standards from September 2013. At the time of writing, approved programmes were offered by 71 UK universities in one or more of the four fields: adult nursing, children’s nursing, learning disabilities nursing and mental health nursing.

The NMC *Standards for pre-registration nursing education* spell out the changes and how they will be embedded, including the academic level at which pre-registration students study, the content of the standards for pre-registration nursing, and the curriculum delivered by the approved education institutions (NMC 2010a).

As required by European Union (EU) directives, all courses must comprise at least 4600 hours, split between 50% theory and 50% practice (including community and hospital practice learning experiences), and must cover specified subjects. Most programmes take three years

about fitness for practice at the point of registration, there is much agreement that the current programmes produce registrants who are better able to adapt to change and implement evidence-based practice than those trained under the old, apprenticeship-style model’ (UKCC 1999).

The move to degree-level registration gained momentum. The NMC, responsible for protecting the public by setting standards of education, conduct and performance for nurses and midwives, began extensive public and professional consultations on the future of pre-registration nursing education in 2007 (Box 3, NMC 2010a). The four UK government health departments were active partners in this review, which was inextricably linked with *Modernising nursing careers*, a major project of the four UK government chief nurses (Department of Health 2006).

Box 3: What the public wants

The NMC consultation found that the public wants nurses who will:

- deliver high quality, safe, essential care to everyone and more complex care in their own field of practice;
- practise in a compassionate, respectful way, maintaining dignity and wellbeing, and communicating effectively;
- protect their safety and promote their wellbeing;
- be responsible and accountable for safe, person-centred, evidence-based practice;
- act with professionalism and integrity, and work within agreed professional, ethical and legal frameworks and processes to maintain and improve standards;

- act on their understanding of how people’s way of life and the location of care delivery influence their health;
- seek out every opportunity to promote health and prevent illness;
- ensure that decisions about care are shared through working in partnership with service users, carers and families, as well as with health and social care professionals and agencies; and
- use leadership skills to supervise and manage others and contribute to planning, delivering and improving future services.

In 2008 the NMC announced that the minimum academic level would in future be a bachelor’s degree (already the case for midwifery). It reasoned that nursing must become a graduate profession to meet the needs of complex care delivery in an increasingly fast-paced healthcare system that demands flexible, responsive and highly skilled practitioners. It said this reflected the gradual transformation of nursing practice through better evidence, stronger professionalism, developments in technology, scientific advances and responsiveness to individual and population healthcare needs.

The UK government endorsed the decision (Department of Health 2009). *‘Degree-level education will provide new nurses with the decision-making skills they need to make high-level judgments in the transformed NHS. This is the right direction of travel if we are to fulfil our ambition to provide higher quality care for all,’* said health minister Ann Keen.

but there is a growing variety of options, including open learning and integrated programmes. All approved HEIs must adhere to the NMC standards, but they have some autonomy on recruitment criteria and the structure and curriculum of their programmes. There is no national curriculum.

The European dimension

There have been minimum standards for pre-registration nursing education in general care across the EU since the late 1970s, within the regulatory framework for mutual recognition of professional qualifications. Their prime purpose is to assist free movement of professionals. All adult field pre-registration programmes in the UK must comply.

The current EU legislation does not specify whether nursing education should be delivered in HEIs (although this is the European trend), nor the level of the qualification (diploma, bachelor's degree, master's degree). The framework is being reviewed: in 2011 the European Commission proposed legislative changes which would open the way for minimum education requirements to include competencies, and for a minimum entry requirement of 12 years' general education or equivalent.

The 1999 Bologna declaration, a pledge by 29 Europe countries including the UK to reform the structures of their higher education systems in a convergent way, was also a key driver of degree-level education for nurses across Europe (European Commission 1999).

Differences across the UK

The NMC is the UK regulatory body and all programmes must meet its standards, but there are differences across the four UK countries.

The process of applying to a pre-registration nursing programme varies by country. The NMC sets basic entry requirements but each university determines its own additional requirements; these vary considerably, from the Open University (OU) that has no set requirements, through to three high A-level grades. Some universities consider applicants with a national or Scottish vocational qualification (NVQ, SVQ) in health at level 3, but others do not.

Selection processes also vary, across and within countries. As a minimum, the NMC requires HEIs to ensure that the selection process provides an opportunity for face-to-face engagement between applicants and selectors, and that it includes representatives from practice learning providers. In Wales all nursing students are required to supply a character reference in addition to the academic reference required by the UCAS process. Many HEIs are using a variety of methods to assess applicants' values and capacity for compassion.

England has a mixed economy of academic level for pre-registration programmes, offered by around 54 universities. Around 85% of nursing students in England currently obtain a diploma in higher education rather than a degree. By September 2013 only degree-level pre-registration nursing programmes will be offered.

Universities in **Scotland** have offered degrees for a number of years. Six universities fulfil the Scottish Government contract for nursing education, and five other non-commissioned universities deliver pre-registration programmes, including the OU. Scotland's chief government nurse is currently undertaking a review of nursing and midwifery education, and the Scottish Funding Council is undertaking a separate review of nursing education and research provision in the university sector.

In **Wales**, all pre-registration nursing programmes have been at undergraduate level since 2004. The five HEIs that offer the approved programmes have worked in partnership since 2002 to develop common tools and procedures for evaluation and assessment.

Northern Ireland offers degree-level programmes in three universities. Queen's University Belfast, the University of Ulster and the Open University are introducing new curriculums in line with the NMC standards in 2012, and stakeholders are reviewing entry and selection processes.

From apprenticeship to higher education

'In the beginning, nursing was small and invisible. Staff were practice/teaching orientated and nursing was not a big player. When we won the tender, which brought in a huge amount of money, people woke up to the importance of nursing - nursing is now the largest income in the university' – nursing dean

Nursing education's journey into higher education was not easy, and the university environment was not quite what the pioneers of academic nursing expected. Academic standards concerned grant income, PhD funding and completion rates, and the number of quality publications, rather than programmes' impact on nursing practice and on service users' health and wellbeing. The profession did not have a strong tradition of scholarship and research, and some universities had doubts about hosting a practice discipline that some thought would dilute academic esteem, research metrics and performance. There were complaints that universities remained male-dominated and had deep-seated prejudices about nursing.

Furthermore, the universities were undergoing enormous changes,

mergers and restructurings, and becoming highly regulated, increasingly corporate and commercially focused. Nurse educationists – ‘many of whom believed they were embarking on a great academic adventure’ – became increasingly confused about who they were and what they could or should be doing (Rolfe 2012).

Fledgling nurse academics find themselves in an environment where they need new skills, experience and support to develop scholarship in a practice discipline. They tend to be older, like those in other practice disciplines in universities such as teacher education or social work. Most develop a clinical career before teaching in a university. That workforce is ageing and not being replaced fast enough. There is no clear career pathway for academic nursing.

Recent interviews with 10 nurse deans/heads of departments in England and Scotland provide insight into the challenges (Ross, in press). Clear differences were revealed between the views of deans working in Russell group universities that offered nursing programmes before 1992, and those in post-1992 universities where nursing was ‘the new kid on the block’.

The study highlights the perception that the authority and credibility of nursing is often related to student numbers and revenue, since nursing education is purchased, rather than funded by the higher education funding councils. Nursing students are the second largest student body, after business students.

The deans talked of having to work in two worlds for two masters - the university and the NHS, ‘leading from the front and pushing from the rear’. Managing the employer/university interface needed navigation skills through both sets of agendas, and the ability to argue and negotiate for nursing. The risk-

averse and over-regulated system made it harder to be inventive.

The deans had different views of the future. Some talked about the risk of universities disinvesting in nursing, in response to reduced commissioning funding. Others highlighted different sorts of risk. As the differentiation between research-intensive and teaching-focused universities continues, some thought nursing might struggle when competing with other disciplines for resources in pre-1992 universities. The more optimistic deans wanted to refashion relationships with health service providers, work across the boundaries of health services and the university, build new partnerships for knowledge production, and use evidence to effect change in nursing practice. They were developing applied research to shape innovative services.

Nursing research

The link between the quality of research and the funding received poses particular difficulties for university nursing departments, most of which began their existence with no nursing research capacity. The Research Assessment Exercise of 2008, undertaken on behalf of the four UK higher education funding councils, evaluated the quality of HEIs’ research. The rankings were used to inform the allocation of research funding. The results were interpreted in contradictory ways, both as an indicator of poor performance, and as a promising sign of the growing capacity and credibility of academic nursing.

Under huge pressure to perform, many nursing departments have made good progress. There were 36 submissions to the nursing panel, and Manchester, Southampton, Ulster and York achieved 4* excellence in over a third of outputs. These are strong centres with research concentration,

nurses leading large multidisciplinary research teams doing patient-focused research, and notable research leaders who can stand alongside leaders from other disciplines.

The teaching and utilisation of research has become an increasingly important component of pre-registration courses, laying foundations for future improvements in research excellence.

‘In my undergraduate genetics degree, the culture was research. All lecturers seemed to do it, and researchers would give lectures. As nursing has moved into universities to facilitate evidence-based practice, good training in research methods would be a good way of changing attitudes’
– Paul Dalpra, nursing student

2.3 The higher education sector

‘Often the relationship between universities and the NHS is one of tension, which can become adversarial rather than mutually supportive. We need to build on these partnerships to develop mutuality, reciprocity and constructive criticism if we are to establish sustainable relationships able to meet student expectations, support mentors and design relevant programmes’ – Fiona Ross, nursing dean

Universities are currently experiencing an unprecedented volume, velocity and variety of change. The drivers can be grouped under the headings of funding, quality, social mobility and fairness, and technology (Coiffait 2011). Around the world the cost-sharing mix for university funding is changing, with the burden shifting from public sources to private ones such as parents, students, businesses and donors. The UK has experienced one of the biggest such

shifts, accelerated by Lord Browne's independent review of higher education funding and student finance (Browne 2010).

HEIs are responding to that shift, and to reductions in public spending, in a variety of ways. These include reducing staff and removing courses that will not generate income. The future impact on nursing departments is difficult to quantify. On the one hand, applications to nursing programmes are likely to benefit from the different funding of student support and the likelihood of finding employment soon after graduating. On the other, nursing departments are already being affected by reductions in teaching numbers, infrastructure and other resources.

The drive to deliver programmes in more cost-effective ways will also affect the way nursing education is constructed. Coiffait says technology promises to be the most revolutionary driver of change in higher education, and the key to solving the other three issues. Though the technological revolution in higher education is only beginning, staff and students are already better connected than ever before, making learning an increasingly social and virtual enterprise.

The performance of universities is closely managed for the value for money/quality of their nursing programmes. They are given targets for recruitment, attrition, outputs and a range of other measures including partnership working. As an example, from 2012-13 NHS London expects better performance and has introduced new measures, including on service user involvement. These were established in partnership with universities and flowed from the tender process.

The number of students who leave pre-registration education without completing their course is a key indicator of the quality of

a programme, and an important determinant of the future supply of qualified staff. Attrition rates vary hugely from one HEI to another, although exact figures are difficult to obtain from many, different definitions are used, and the data are inadequate.

The only systematically reported data, from NHS Scotland, show attrition rates for pre-registration diploma students of around 27% for the three most recent cohorts. Scotland uses a different definition and way of measuring than England, so its attrition rates appear much higher. Data for England suggest that the proportion of students dropping out by the end of the second year fell from over 12% for the 2008-09 intake to over 8% for 2009-10 (but these figures exclude the final year and do not cover London). Overall the percentage of students who fail to complete their studies appears to be falling, owing to significantly better screening of applicants and improved support for students (Buchan & Seccombe 2012).

2.4 Commissioning and funding nursing education

'Employers want to know what students can do at different stages of the programme, and what they can expect of a newly qualified nurse. Universities want the freedom to develop curricula that reflect the autonomy and choice of degree-level programmes. Commissioners (who fund the programmes), employers, universities and their partner organizations want education programmes that are flexible and adaptable to local needs' – NMC

Major challenges flow from how nursing education is commissioned and funded. Unlike medical education, which is university-led, the commissioning of nursing education - the process by which education priorities are set and resources are allocated - is employer-led using a purchaser-provider model. It is delivered in partnership by health service providers and universities.

The true cost of nursing education is rarely quantified. The estimated costs associated with pre-registration nursing and midwifery education and support in England were almost £1bn in 2008-9, comprising over £568m for tuition costs and over £352m for bursaries (Prime Minister's Commission on the Future of Nursing and Midwifery in England 2010). The four UK countries allocate and manage these resources differently and through different bodies.

Commissioning

'Although policy changes, demographics and increasing migration suggest that the requirement for adult nurses will continue to increase, many strategic health authorities are decreasing commissions. This poses a potential risk to service delivery... There is a significant risk that this could lead to future shortages' – Centre for Workforce Intelligence

The number of nursing student places commissioned is the key determinant of future intakes to education and subsequent labour market supply. The number of places available across the UK for 2012-2013 fell again to around 21,400. This will also mean reductions in the numbers of lecturers and courses, and threats to the viability of some university programmes and departments.

This reduction in places will also reduce the new supply to the

workforce. Far fewer nurses are now recruited from overseas, so the supply of new nurses to the NHS and other employers comes mainly from pre-registration nursing education. The predictability and security of this supply is uncertain in the longer term.

Comparatively limited data are available on applicants and flows into nursing education, and it is difficult to pin down precise trends. It appears that more people continue to apply to study for nursing qualifications. Applications for nursing degree courses were up again by 25% in 2012, while the number of applications for diploma courses continued to fall. Overall numbers of applications (choices) for all types of pre-registration nursing programme were 3% higher in 2012. The number of applications to nursing degree courses easily exceeds those to all other higher education courses, with the number

of UK-domiciled applicants at an all-time high this year of 58,123 (Buchan & Seccombe 2012).

What explains the continuing rise shown in Figure 2? Nursing provides relatively secure employment. There is uncertainty about how changes to higher education funding arrangements will affect financial support for students. These factors may also help to account for the changing age profile: the average age of a nursing student is 29.

The impact of changes to pensions and retirement policies is another unknown. Student funding support is a further unpredictable influence on applications and attrition: on average, means-tested bursaries for nursing degree students are lower than non-means tested bursaries for diploma students. The bursary system is different across the four UK countries.

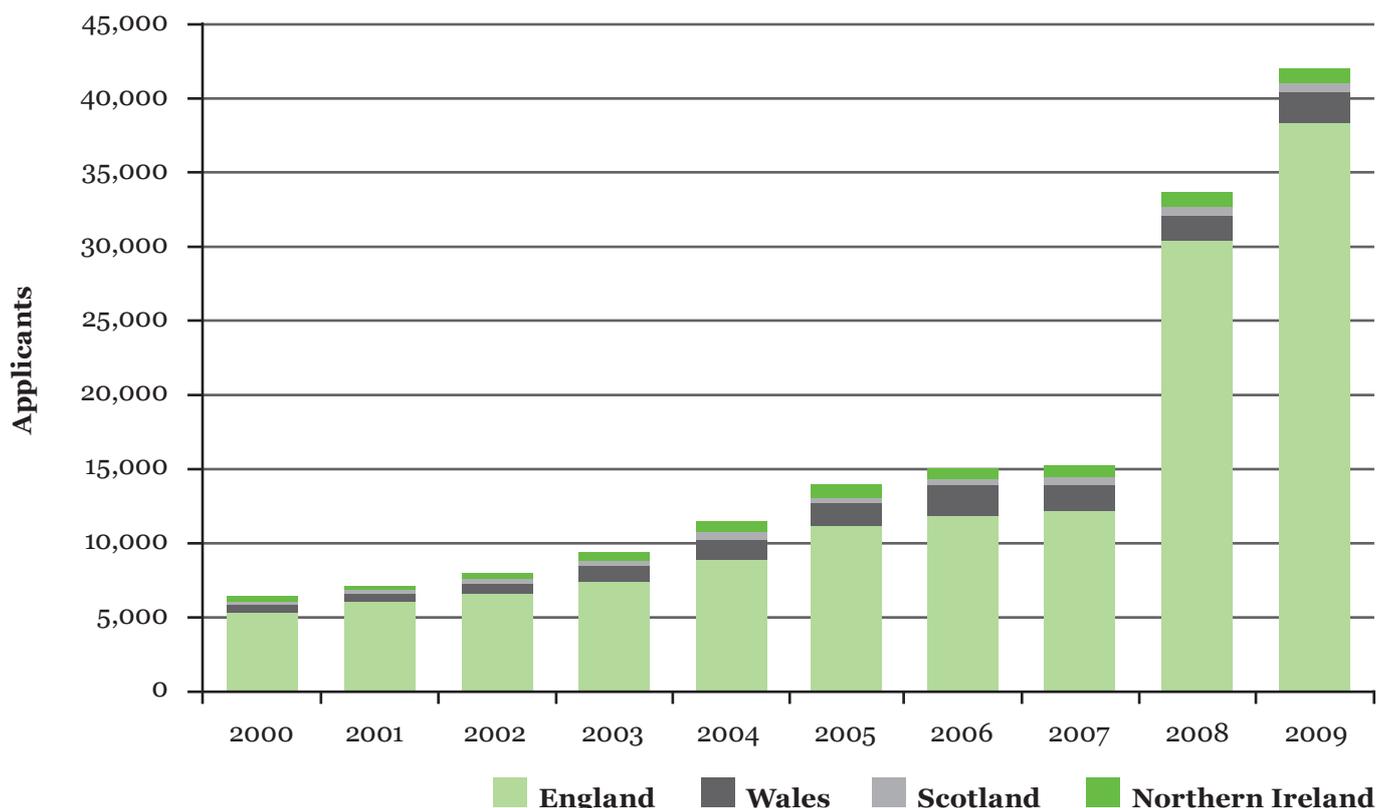
In summary, historically large numbers of students are choosing to apply for nursing programmes, with proportionately more applications coming from older cohorts - but the numbers starting courses are falling as the number of funded places falls. It is not yet clear whether the move to degree-level education will reduce the number of applicants, but there is little sign that it will.

A locally led approach

'Employers have confidence that through a co-operative and collaborative approach between service and education providers, the future workforce will not only continue to deliver quality care but will also be equipped to develop and deliver new and dynamic services for patients' – NHS Employers

The government white paper *Equity and excellence: liberating the NHS* said a top-down

Figure 2: Applicants for pre-registration nursing education at HEIs, 2000-2009
(Source: UCAS)



management approach to funding and commissioning health professional education did not allow accountability for decisions affecting workforce supply and demand to sit in the right place (Department of Health 2010). *'It is time to give employers greater autonomy and accountability for planning and developing the workforce, alongside greater professional ownership of the quality of education and training,'* it said.

The government is committed to the principle of tariffs for education and training as the foundation of a transparent funding regime. It plans to introduce a tariff-based system to enable a national approach to the funding of all clinical placements (medical and non-medical) and postgraduate medical programmes, to support 'a level playing field between providers and professions'.

The system will aim to ensure that education and training commissioning is aligned locally and nationally with the commissioning of services. Employers and staff will agree plans and funding for workforce development and training; their decisions will determine education commissioning plans. All providers of healthcare services will meet the costs of education and training (Department of Health 2010).

In England, the health education commissioning structure is changing from 2013. Oversight of health professional education has been transferred from the Department of Health to a new body, Health Education England (HEE). Its remit is to ensure that education, training, and workforce development drives quality public health and patient outcomes (Department of Health 2012b).

Education commissioning for nurses, midwives, allied health professionals, doctors, and others will be led nationally through HEE.

Employers will have greater powers through new local education and training boards (LETBs), consisting mainly of regional service providers. They will make decisions on commissioning workforce and nursing numbers, NHS staff development, and where training will take place. They will also oversee quality and contract performance management from 2013, using the national Education Outcomes Framework (EOF), perhaps supplemented with additional metrics (Department of Health 2012c). The EOF domains are excellent education, competent and capable staff, adaptable and flexible workforce, NHS values and behaviours, and widening participation.

The LETBs will consult local education providers and other local stakeholders. The focus in the Health and Social Care Act on 'any qualified provider' is stimulating a rise in the number and diversity of non-NHS service providers. As potential major employers as well as educators of NHS-trained nurses, they will need to become integrally involved in workforce planning.

'I want local education and training boards to make a priority of the interface and involvement of the patients and the public. You do it by making it your purpose. If you get that right and work with what is in the NHS Constitution, you will probably get nearer to being right' – Sir Keith Pearson, chairman, Health Education England

The NHS Commissioning Board will provide national patient and public oversight of healthcare providers' funding plans for training and education in England, and check that they reflect its strategic commissioning intentions. Clinical commissioning groups will provide this oversight at local level. The Centre for Workforce Intelligence will provide information and analysis.

Experience in the 1990s, and again in 2006 when drastic cuts were made in nursing education to meet a service funding shortfall, highlight the risks of the locally-led approach. Under cost pressure, local employers often take a narrow view of future requirements, and overlook the staffing needs of non-NHS employers (Buchan & Seccombe 2012). Furthermore, the nursing workforce is in many ways a pan-UK resource, with nurses often crossing internal UK borders to train and work, including providing specialist services.

Without a well-developed oversight process, there may be a significant underestimate of future requirements. This could repeat the damaging 'boom and bust' cycle that has long characterised nursing workforce planning.

Funding

Funding for health professional education comes from three streams: student fees; higher education funding council allocations to medical schools for teaching; and the largest stream, the undergraduate medical and dental service increment for teaching (SIFT or equivalent) to hospitals and GPs (MEDEV 2011).

In England, the Department of Health allocates SIFT, via the 10 strategic health authorities (SHAs), to NHS trusts and general practices to offset the service costs associated with teaching. Similar schemes are administered by the Scottish Parliament - additional cost of teaching (ACT); Welsh Government - SIFT; and the Northern Ireland Assembly - supplement for undergraduate medical and dental education (SUMDE).

SIFT is traditionally divided into two elements: facilities (around 80%) and clinical placements (around 20%). Facilities may include tangible assets and human

resources; clinical placements may also be a form of facility. Clinical placement budgets are required to justify clinical placement payments based on student weeks. The payment per student week varies widely both within and between regions. The SHA has a learning and development agreement with most recipients of SIFT money, which specifies the number of students and weeks, and may (but often does not) specify how SIFT is allocated.

‘It is important to ensure that SIFT follows the student, enabling more teaching to be supported outside traditional teaching hospitals, but these changes need to be carefully managed to ensure that trusts are not destabilized’ – HEFCE/ Department of Health (1999)

SIFT is a component of the multiprofessional education and training levy (MPET), which also includes MADEL (postgraduate medical), D-SIFT (dental), NMET (the non-medical education and training levy) and some other clinical specialties. In England MPET had a budget of £4.9bn in 2012-13, in addition to investment by NHS organizations in their own staff.

NMET funds tuition for nurses, midwives and allied health professionals as well as the NHS bursary scheme, £2bn in 2011-2012. In universities in 2011-12, £805m of NMET paid for non-medical tuition fees; £169m funded continuing professional development courses offered by universities; and £525m funded the NHS bursary paid to students for maintenance support. Funding for nursing education is not ring-fenced, and can be reallocated to cover service funding shortfalls. This contrasts with medical commissioning, which is centrally funded (through HEFCE) with funding flowing from the DH.

2.5 Changes in the nursing workforce

‘The landscape has changed considerably, with the need for a smaller, sustainable, retainable, graduate workforce trained and prepared to be clinical leaders in whatever capacity, as medics are. Part of that training then is very much focused on how they support and develop members of the team they lead’ – nurse dean

To meet public expectations, and give care that is safe and effective, nursing practice must be based on evidence, knowledge, and analytical and problem-solving skills acquired through degree-level education. Government-commissioned work envisages the nurses of tomorrow as practitioners, partners and leaders (Maben & Griffiths 2008):

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

This vision was further expanded by the NMC consultation, which concluded – albeit with a dissenting minority - that the necessary competences would best be acquired through degree-level education (NMC 2010a) (Box 4). The new cadre of all-graduate registered nurses (RNs) will be expected to provide linchpin clinical leadership; coordinate and closely supervise care delivery; and deliver some complex care.

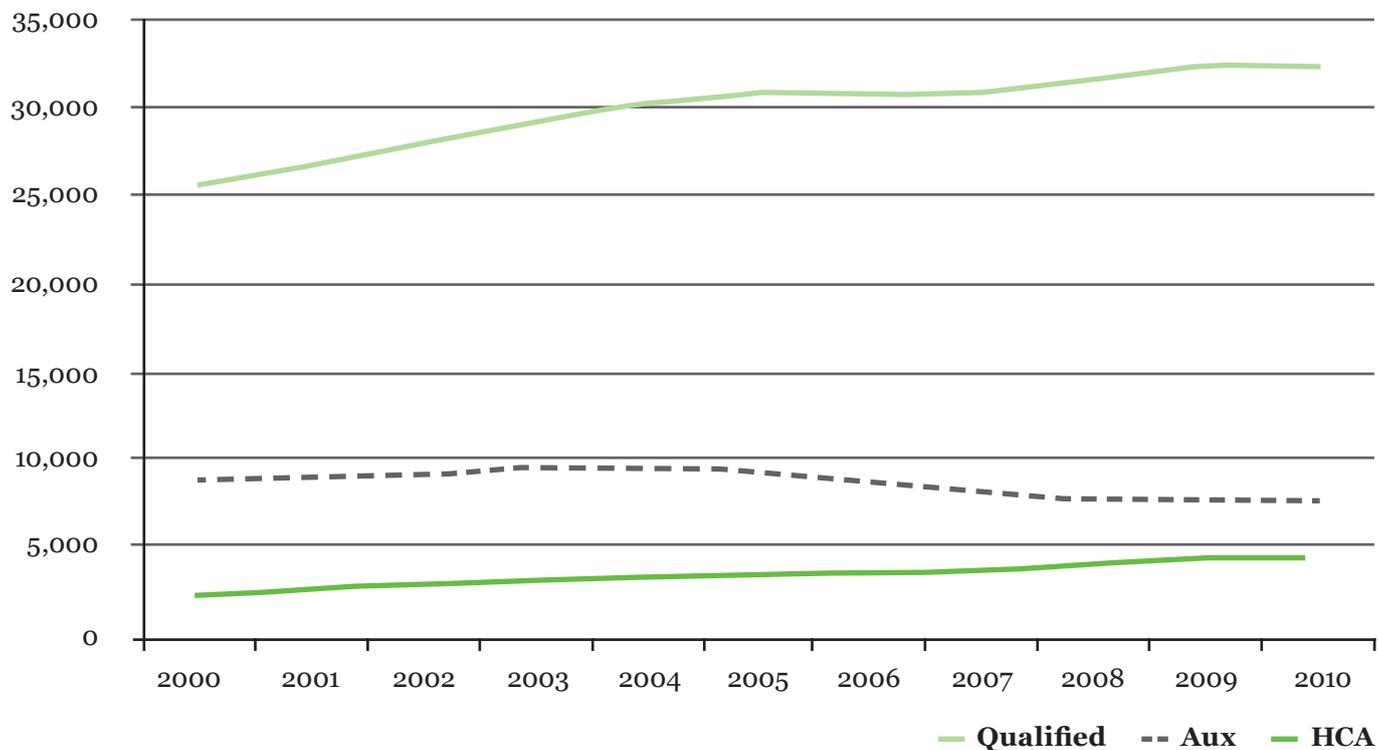
Box 4: Graduate nurse competences

The NMC says graduate nurses will be able to:

- practise independently and make autonomous decisions;
- think analytically, using higher levels of professional judgment and decision-making in increasingly complex care environments;
- plan, deliver and evaluate effective, evidence-based care safely and confidently;
- provide complex care using the latest technology;
- drive up standards and quality;
- manage resources and work across service boundaries;
- lead, delegate, supervise and challenge other nurses and healthcare professionals;
- lead and participate in multidisciplinary teams, where many colleagues are educated to at least graduate level; and
- provide leadership in promoting and sustaining change and innovation, developing services and using technical advances to meet future needs and expectations.

Nursing education issues were not a focus of the controversial Health and Social Care Act 2012. Yet the act and other healthcare reforms in England are having a major, as yet unquantifiable impact on nursing and nursing education. Scotland, Wales and Northern Ireland, which since devolution in 1998 have been responsible for determining health policy, are not introducing major NHS reforms and their policy and planning environment for nursing education is more stable.

Figure 3: NHS staffing, England, 2000-2010: qualified nursing staff, nursing auxiliaries and healthcare assistants (whole time equivalent)
(Source: NHS Information Centre 2012)



All four countries are deeply affected by the economic downturn, which has led to policy decisions to make dramatic reductions in health and education funding. Policy-makers, including ministers and healthcare employers, have important and difficult decisions to make about health funding priorities. On the plus side, they retain control over most factors that will determine future NHS nursing numbers.

'In the past, nursing shortages have been tackled by having more nurses. Over the next 10 years the emphasis will shift to having more effective nursing' – James Buchan, workforce expert

Nurses comprise the largest part of the workforce in the NHS - Europe's biggest employer - and the largest group of registered professionals in British health services. There are well over 600,000 registered nurses in the UK, 90% of them women, and an unknown but growing number

of healthcare support workers who carry out nursing duties under their supervision.

In 2011 NHS nurse staffing numbers fell for the first time in a decade (Buchan & Seccombe 2012). The overall numbers of newly qualified nurses (NQNs) entering the labour market will fall as reductions in the number of places commissioned affect the numbers graduating.

The sheer size of the workforce presents huge challenges to policy-makers, and to data collection, analysis and planning. Policy analysis and response is constrained by incomplete and outdated data, although policy choices have major implications for the size, shape and sustainability of the nursing workforce, for individual nurses, and for care (Buchan & Seccombe 2011a).

Robust baseline information is essential, but nursing staff are often

counted together in undifferentiated groupings that conceal their wide range of qualifications, grades, roles and salaries. Nurses and midwives may be counted and categorized together, like registered and non-registered staff. NHS data on the nursing workforce cannot easily be aggregated up to UK level because of differences in definitions and collection methods in the four countries.

Disaggregated workforce statistics are generally available only for the NHS, and thus exclude thousands of staff in the independent and voluntary sectors. Data on nurses employed by nursing homes, private hospitals, charities and other non-NHS employers have actually reduced in coverage, quality and completeness, despite the need to capture non-NHS employment trends and involve non-NHS employers in workforce planning (Buchan & Seccombe 2011b).

The arrival of the graduate nurse is just one of many drivers affecting skill and staff mix, in the quest to find the combination of staff that will contain costs and make best use of expensive and sometimes scarce professional skills. Nurses have always devolved tasks that apparently required less expertise to non-registered assistants, and indeed to nursing students until they became supernumerary. Since the foundation of the NHS, a range of non-registered staff has provided hands-on care in settings, shifts and places where it was difficult to recruit or pay for qualified nurses. These low paid, low status nursing auxiliaries and nursing assistants (now collectively called healthcare support workers, or HCSWs) deliver much of the care, with greater or lesser supervision.

Although changes in the division of labour are nothing new, the pace is accelerating. There is a proliferation of new roles and job descriptions, creating or expanding roles such as advanced nurse practitioner, physician assistant, assistant practitioner and healthcare assistant (HCA). These roles and functions are very varied, sometimes poorly defined, and lack consistency across employers (Prime Minister's Commission on the Future of Nursing and Midwifery in England 2010). In the NHS NQNs start work at Agenda for Change band 5, while a support worker may be paid at band 2 or 3. Some trusts have introduced assistant practitioner roles in Agenda for Change band 4, and enhanced roles for other support workers in bands 1-4.

The scale of skill mix change is hard to quantify, and detailed comparisons over time are difficult because data on non-registered staff have always been scarce and remain incomplete. The NHS Workforce Census, which provides figures on NHS staff in England, has a statistical category 'Support

to doctors and nursing staff' that covers a diverse group including healthcare assistants, assistant practitioners, nursing assistants, nursing auxiliaries, nursery nurses, porters and medical secretaries (NHS Information Centre 2012).

The figures distinguish between HCAs and 'nursing assistants/auxiliaries', but it is not clear what this means in practice. Inconsistent use of the HCA title and different employers' use of alternative titles for the same category of staff preclude an accurate count of the number in the NHS. The numbers and trends outside the NHS, for example in nursing homes, remain largely unknown.

In 2011, the NHS in England employed 53,140 HCAs (headcount; many work part-time and the full-time equivalent is 44,787), around 4% of the workforce. There was an increase of nearly 24,000 HCAs (82%) in 2001-2011, an average annual rise of over 6%. This sounds dramatic but the evidence does not tell us how many HCAs were previously described as auxiliaries or assistants. Meanwhile the number of nursing auxiliaries and assistants has declined and some, perhaps many, have been rebadged as HCAs (Figure 3).

Absolute numbers in any case can only tell us so much, as it is essential to know what people do, their role in the team, the nature of the skill mix and the health outcomes. What has undoubtedly changed is that HCSWs are receiving much more attention as an apparently cost-effective way of delivering care. NHS employers claim that the move to degree-level nursing registration will lead them to make more use of assistant practitioners (NHS Employers 2009), but the trend is not new and is a global one (All-Party Parliamentary Group on Global Health and Africa All-Party Parliamentary Group 2012).

Overall, these skill mix changes will challenge what we mean by 'nursing' (Buchan & Seccombe 2011b) (Box 5).

Box 5: Skill mix and the changing face of nursing

- Graduate nurses, possibly fewer in number, in advanced/specialist roles, managing cases and teams, diagnosing and prescribing.
- Increasing use of support workers, especially healthcare assistants and assistant practitioners.
- Much more emphasis on self-care by service users.
- Greater involvement of families and carers in care.

The dilution of skill mix should be viewed against the evidence on the links between well qualified nursing staff and improved patient, nurse and financial outcomes (Unruh & Fottler 2006). The research evidence of the association between nurse staffing levels and patient outcomes is compelling (Ball 2010). Studies have found a direct correlation between a lower proportion of RNs and the delivery of lower quality of care, and affirm the economic value of well qualified and effectively deployed nurses. The best-staffed NHS trusts have significantly lower mortality rates (Rafferty et al 2007), and better nurse staffing is associated with reduced risk of complications and lower mortality rates. Evidence of the negative effect of inadequate staffing is even more striking – as the experience of Mid Staffordshire demonstrates (Ball 2010).

The concerns and the evidence have led the RCN and other opinion-leaders to call for more rational planning to ensure safe staffing, and systematic training and regulation of some HCSWs.

2.6 Regulation

The regulatory landscapes

of health services and higher education are highly complex, and even more so where they intersect in matters that influence the education of health professionals. They will become even more complex in England as responsibilities devolve to LETBs, with education commissioners requiring universities to satisfy expectations for quality and contract value.

Furthermore, some regulatory bodies have UK-wide remits while others are specific to the different UK countries, and do not have identical functions.

Like healthcare providers, universities are monitored and assessed by more than one agency. The Quality Assurance Agency audits HEIs and their quality assurance processes every five years, and the universities undertake internal quality reviews. Educators and their practice partner organizations must update their programmes to comply with system requirements.

In health care there are broadly two types of regulation: of professions, and of systems (Jaeger 2011). Professional regulators set standards for education and practice, maintain registers of qualified professionals and deal with issues of misconduct. Within this field, regulation can be statutory or voluntary.

Statutory regulators such as the NMC have legal powers to make registration mandatory, and the disciplinary decisions they take, for example striking off, are recognized in law. The Council for Healthcare Regulatory Excellence oversees the work of the UK's nine statutory professional regulators.

Systems regulators have different powers and remits across the UK, but are generally concerned with the quality of healthcare environments. The Care Quality Commission (CQC), the independent regulator of all health and social care services in England, is required – as are the equivalent bodies elsewhere in the UK – to ensure that care provided by hospitals, dentists, ambulances, care homes, and services in people's own homes and elsewhere meets government standards of quality and safety.

The NMC standards for pre-registration nursing education comprise standards for competence (what nursing students must do and achieve during their programme) as well as standards for education (about the framework within which programmes must be delivered). These mandatory requirements include those relating to teaching, learning and assessment of students.

NMC requirements underpin the standards and must be met by all education institutions approved to provide UK nursing programmes. The NMC normally approves a programme for up to five years, checks compliance before allowing it to run, and monitors it. NMC quality assurance processes measure the performance of HEIs and their partner practice learning providers in programme development and delivery. Educational audits of all nursing practice placements are carried out every two years, and compliance is checked annually. HEIs have processes for student evaluation of placements that feed into the processes for removal and reallocation of students where necessary.

Educational audit is also increasingly highlighting adverse clinical governance issues. The NMC requires all HEIs to have an escalating concerns policy, which must be introduced to nursing students. Through the NMC code

(2008a) it also requires individual teachers to raise concerns when they witness potential risk in clinical settings, and to take seriously their responsibilities to deal with students' concerns about the quality of practice placements, especially where these point to wider patient safety issues (NMC 2012). Nursing students also have responsibilities to raise and escalate concerns if they think the care environment is putting patients at risk.

The CQC and the NMC have developed a system for sharing information; their staff meet regularly; and they occasionally conduct joint inspections when there is a major cause for concern. HEIs, the CQC and the NMC do not routinely engage in joint discussions. HEIs should use CQC intelligence about these settings when they evaluate how they teach and assess students.

The burden of audit requirements on HEIs and healthcare providers is large, and growing. There is unnecessary duplication of effort with little added benefit. The financial cost of these audit processes to education providers, education commissioners and regulators is unknown. The commission supports ongoing work to reduce this burden.

'HEIs are currently reviewed on the quality of their provision by a range of different stakeholders, including the regulatory body and education commissioners. These different quality assurance processes all report on broadly similar issues and yet use a range of different formats which places unnecessary pressure on HEIs. A single quality assurance framework, incorporating both HEI and practice components, would remove the duplication in reporting that occurs at present' – Open University

Part 3: What we learned

This section of the report summarises the main points the commission learned that lay within its brief. It begins with a summary of what was heard from health service users and carers, whose needs and involvement must always be the golden threads that run through all nursing education. The main emerging themes from all sources are then outlined.

Overall, the commission learned of a range of challenges to HEIs and health service organizations that must be tackled to support improvements in nursing education, to ensure the new NMC standards are fully implemented, and to promote high quality patient-centred care.

These challenges include providing adequate support and assessment to ensure students' continuing clinical skills and competence; responding to changing regulations; strengthening nursing career structures and pathways; and supporting academics and mentors.

There was also evidence of sophisticated understanding of the needs of a practice profession, proactive engagement with the education process, and many innovative developments to address these challenges, despite the difficult contexts of the health and higher education sectors.

More high-quality systematic research, including longitudinal and multi-site studies, is needed to help fill the evidence gaps and assess how well nursing education prepares future practitioners.

The commission's review of the evidence did not reveal any major shortcomings in nursing education that could be held directly responsible for poor practice or the perceived decline in standards of care. Nor did it find any evidence that degree-level registration was

damaging to patient care; on the contrary, there was evidence that it has played and will continue to play a key role in driving up standards and preparing a nursing workforce fit for the future.

3.1 Views from service users and carers

'There is a perception amongst some patients that because nurses are trained more widely in technical clinical skills, they do not feel that fundamental care is sufficiently advanced for them to consider a full part of their role. There are also concerns that the emphasis on theoretical learning rather than well supervised practice does not give nurses the skills and experience they need to provide care' – Patients Association

Concerns about standards of care were a constant theme in the 11 written submissions from organizations representing health service users and carers, and oral evidence from four of them. This related partly to perceptions that nurses were sometimes unable or unwilling to deliver the fundamentals of care. They cited numerous patient stories and reports (some going back over a decade) that revealed lack of knowledge of the fundamentals of care and their contribution to effectiveness, safety and humanity.

Mind cited evidence that people's needs in a mental health crisis focused on human interaction. They wanted to be treated in a warm, caring and respectful way, have time with staff and to talk, and for staff to be able to 'be themselves'. This was missing from many people's experiences. There was also much to praise, however.

'The team that supports me believes fully that I have the right to decide the treatment I need and this extends to crisis. This allows me to work collaboratively with them and I trust them' – mental health service user

The chairman of the Commission on Dignity in Care for Older People, Sir Keith Pearson, said NQNs were better aligned to the contemporary needs of older people than some newly qualified doctors (Local Government Association et al 2012). They were providing a range of support for older people that might only have been dreamed of 10 years ago – *'the evidence is there that they are delivering that complexity'*.

The service user organizations acknowledged that nurses were trying to deliver good care despite often being understaffed, stressed and poorly supported. Some organizations had made extensive recommendations to NHS employers to improve staff care and support.

'We were concerned that people were working with high demands and risk without necessarily receiving good leadership and support. Nurses' own values and learning may be undermined or corroded by organizational cultures' – Mind

The organizations called for more attention to be paid to their own areas of work in pre-registration curriculums (care of older people; dementia; mental health; multiple sclerosis; diabetes; cancer; acute and chronic pain; cardiac care; arthritis; and carer awareness). They praised and in some cases invested in specialist nurses, including employing them as advisers, employing them to deliver services, and funding them on courses, and deplored the impact of health service spending cuts on specialist posts.

It was recognized that the right balance was needed between generalist and specialist education

at undergraduate level. However, in view of the growing numbers of people with long-term conditions, and the drive for patient-centred care, they wanted generalist skills to respond to these trends to be enhanced, including shared decision-making and self-management.

‘People with dementia and carers don’t expect nurses to have an in-depth knowledge of dementia. However, recognising the condition, developing sensitive communication skills, handling situations with dignity and respect and seeing the individual rather than the disease can make a huge difference. These are the minimum skills that the public expect from a registered nurse’ – Alzheimer’s Society

The impact on students of working in different care settings, including in the community, could not be underestimated. It gave them the necessary direct experience of caring for and learning from people with particular conditions. They also became more aware of the roles and needs of carers and families as members of the care team, especially in placements outside hospitals.

The service user organizations called for much greater public and patient involvement in nursing education, and spoke of the willingness of patients and carers to be involved in training. The key areas highlighted were involvement in curriculum development; programme delivery; recruitment; student assessment; mentorship; and preceptorship. Much evidence from them and other submissions, especially from universities, described how this involvement was being scaled up.

3.2 Other evidence and views

The main findings of our overall literature review are summarised in Box 6 (Watts & Gordon 2012a). They were all echoed in the other evidence and views submitted to the commission.

Box 6: Main findings of the literature review

- The shift to degree-level registration constitutes a whole-systems change for nursing education, and presents a range of challenges to HEIs.
- The move of nursing education into higher education, and changes in nursing roles, may have ‘uncoupled’ education and practice.
- A range of educational approaches is needed to address the theory-practice gap. Practice learning experiences play a key role and mentoring provides essential student support.
- Effective understanding of collaboration and interprofessional working is a key component of pre-registration nursing education.
- There may be variation in levels of practical skill attained at the point of qualification.
- Good preceptorship is essential in preparing NQNs for the stressful transition from student, but current provision is variable.

The future nursing workforce

Some key, linked workforce issues were raised: the capacity of the

current nursing workforce, the shape of the future nursing workforce, and the nursing academic workforce. It was pointed out that most of the nurses who will deliver care for the next 10 years and more are already in the profession and mainly at work, so there must be more emphasis on continuing professional development (CPD) and retaining staff.

Many submissions supported the current rethinking and reshaping of nursing to reflect changes in the complexity, technology, settings and delivery of care. There should be more emphasis on public health, health promotion and illness prevention, with appropriate placements. Nursing education needed a much stronger community focus.

The question of core purpose was also posed: was nursing education preparing nurses to manage care delivered by others, or to nurse patients themselves, or a combination of both?

There was much concern about the number of care-givers who are not regulated or registered. It was said that the general public needed to know the difference between a carer, a healthcare support worker and a registered nurse.

There was a strong emphasis on individual leadership qualities, and the need to develop students so they could understand what would be expected of them in future - including leading the nursing agenda. Many submissions advocated much more strategic and influential nursing leadership.

Degree-level registration

There was overwhelming support for the need to have a graduate nursing workforce. Submissions emphasised recognition of the achievement of securing gradueness as a major historical change, and a right for the profession of nursing, as it is for

every other health profession. This would improve care and the calibre of the nursing workforce.

'We wanted to slay the myth of the over-qualified nurse. We could find no evidence that having less qualified nurses would improve the outcomes for patients – quite the reverse: if you have well qualified nurses you deliver better outcomes for patients' – Sir Keith Pearson, chairman, Commission on Dignity in Care for Older People

Early studies by Helen Sinclair and colleagues following up nurse graduates from the University of Edinburgh showed that most stayed in clinical roles and tended to work in the community (Sinclair et al 1984). Two surveys in the early 1980s suggested that graduates from integrated courses with degrees and health visitor training remained in nursing, and predominantly in health visiting (Drennan et al 2012). Other research from the UK and US shows that graduate nurses are more committed to a professional career and stay in the profession. They are the most in demand and the first to get jobs (McLeod Clark, oral evidence).

A US study found that a 10% increase in the proportion of nurses holding a bachelor's degree was associated with a 5% decrease in both the likelihood of patients dying within 30 days of admission to hospitals in Pennsylvania, and the odds of failure to rescue. It concluded that when there are higher proportions of nurses educated at the baccalaureate level or higher, surgical patients experience lower mortality and failure-to-rescue rates (Aiken et al 2003).

These findings add to the growing body of evidence on graduate nurse outcomes – although the move to degree-level registration is incomplete in England, and the outcomes of the new programmes will not be known until 2015 at the

earliest. More studies will be needed to evaluate the outcomes of the new degree level courses.

Students told the commission that critical thinking skills were vital, and refuted the idea that having a degree in nursing was an obstacle to compassionate care. They displayed a mind-set of inquiry and research awareness rather than unthinking acceptance of tradition.

The shift to degree-level registration constituted a whole-systems change for nursing education, and implementation of NMC standards for pre-registration nursing programmes presented a number of challenges for universities and health service providers. There was a strong call to re-educate society about nursing, and market it more effectively.

'The nursing community must find a better way to communicate with the public. The public's experience of the NHS is greatly influenced by their expectations. If they don't understand that what nurses do has changed, how can we expect them to believe they have received exceptional service?' – nursing student

Learning to nurse

A major review of pre-registration nursing and midwifery programmes in Scotland reported the predominant opinion of HEIs, clinicians, managers, students, carers and service users that NQNs were fit for practice at the point of registration (Lauder et al 2008) (Box 7). The programmes evaluated were using the NMC's pre-2010 standards.

There were calls for further detailed evaluation of the standards for pre-registration nursing education, following the example of this large study.

Most respondents thought the NMC *Standards for pre-registration*

nursing education (NMC 2010a) were fit for purpose. The way the standards were implemented would be crucial, and they should be given time to bed down.

'We are always playing catch-up and dealing with the unintended consequences of the policies that we were previously implementing. What is needed is an evaluation of where we are currently.'

Some submissions said the current curriculum was still based on an 'illness model approach' and required a radical rethink, to strengthen generic knowledge and skills to meet changing health needs and encompass the social context of health, wellbeing and illness. Others felt this was already the direction of travel.

The review identified a range of initiatives in learning provision, support and assessment. Practice learning experiences and the varying quality of mentorship featured strongly. Collaboration between mentors, practice education facilitators, senior trust staff and HEIs was key. Effective mentorship required provider organizations to invest in financial and human resources to promote the quality of the practice learning environments.

There was clear support for student recruitment processes that made values-based assessments and explored academic achievement and ability, experience in care settings, and the motivation for choosing nursing. Recruitment should balance academic excellence and values. Numeracy and literacy continued to be major concerns during recruitment and training.

A number of written submissions said pre-registration education was not the only or even the main driver of high quality nursing. Other issues that some considered more pertinent to the quality of care included the culture of the organizations

where students and new graduates work; inadequate career pathways and continuing professional development; and insufficient preparation and regulation of healthcare support workers.

The importance of nurses having ‘a sense of belonging’, generating identification with and pride in the profession, was often mentioned, along with fears that it had been lost in the move to higher education. It was not clear, though, how approaches to nursing education might best influence, nurture and sustain professional attitudes and behaviours.

It was argued that the move to a graduate profession should stimulate and be supported by more collaborative learning opportunities for students and practitioners from different professions.

Box 7: Are newly qualified nurses fit for practice?

Newly qualified nurses are perceived as being fit for practice at the point of registration. Students themselves also consider that they are fit for practice at the point of registration. This is a fundamental shift from the findings of earlier studies’

This was a key finding of a major review of pre-registration nursing and midwifery programmes in Scotland (Lauder et al 2008). Commissioned and funded by NHS Education for Scotland, it was arguably the most comprehensive and methodologically complex nursing curriculum evaluation yet undertaken in the UK.

The study also found that new registrants were more aware

than ever of their considerable legal and professional accountability for care. This might manifest as a lack of confidence, but they could be supported by good mentorship and further professional development.

The recognition by practising nurses that pre-registration education was only the start of a lifelong educational journey was a strong theme. There was no expectation that NQNs should be the ‘complete package’. Competence and confidence were part of a journey with various landmark stations, and not a fixed end point.

Continuing professional development

Retaining staff and encouraging them to manage and deliver compassionate care needed urgent attention, and much more investment and support for CPD, though it was often considered a low priority at a time of financial constraint.

Pre-registration education should be seen in the context of career-long learning, and be followed by preceptorship for NQNs, and ongoing support and development.

There were unrealistic expectations of NQNs. The transition from student to staff nurse creates a period of uncertainty, with new responsibilities and accountabilities being a source of stress and pressure. Preceptorship helps to address this, but provision is variable.

To continue to view pre-registration education in isolation from a comprehensive review of CPD would be a mistake. Tomorrow’s nurses take a lead from the nurses of today and must also be the beneficiaries of new ideas and practices.

There was strong concern at the continuing lack of a nationally agreed career path for nurses. The case was powerfully and consistently made throughout the witness sessions. *‘How the graduate nurse becomes a nurse consultant is total serendipity, and I just don’t think that is sustainable.’* There was also a need to address the ageing and quality of the nursing academic workforce. Concerns were raised about the paucity of nurses leading academic departments, and the lack of higher degrees required in senior academic nursing roles.

Infrastructure

Nursing education was most effective when there were constructive partnerships between HEIs, healthcare employers, the public and others. Better integration between service and education would help ensure robust and well-supported learning that put service users at the centre. Employers must be fully committed to their educational responsibilities. The national approaches to education adopted in Wales, Scotland and Northern Ireland provided examples. Closer collaboration between the health and social care sectors, supported by interprofessional learning (IPE), was also urged.

Healthcare providers and universities are monitored and assessed by a number of agencies. A number of submissions highlighted the plethora of regulatory systems, and called for the processes to be streamlined and duplication reduced.

The way in which funding was allocated was not thought to support best outcomes. The lack of financial incentives was a major concern, and the disparity between funding levels for medical and nursing education was often mentioned. Sustainable funding was needed to ensure good mentorship and to increase the number of placements in general practice, community and other areas.

Part 4: The way forward

The large degree of overlap between the themes that emerged from the literature review, the written and oral submissions, and the visits and meetings gave the commission a clear steer on what priorities to address. It chose six main themes, based on its assessment of the weight of the evidence, the importance and urgency of the issues, and the potential for action.

This section of the report addresses each theme in turn, setting out the main issues, solutions and recommendations. The themes are the future nursing workforce; degree-level registration; learning to nurse; continuing professional development; patient and public involvement in nursing education; and the education infrastructure.

Theme 1: The future nursing workforce

Nursing education is not an end in itself: its primary purpose is to prepare the future nursing workforce. The key overarching question that emerged from the evidence and commission discussions - what shape this workforce should be - links with judgments about what future health services could and should be like, and what knowledge and skills nurses will need.

Decisions about these issues should drive nursing education, while ensuring that workforce preparation is sufficiently flexible to respond to the changing health needs of individuals and society. *‘Until we understand what is needed to equip the workforce to deliver future health care, it is difficult to ensure that we have developed training and support that is fit for purpose.’*

Perhaps surprisingly, given all the adverse comment, NQNs are

generally thought to be well prepared to meet current service needs. Nursing education cannot stand still, however, and preparing future generations of nurses presents increasingly complex challenges (NMC 2010a). The UK will need a dedicated nursing workforce ready to work in a range of sectors, and in many different ways, to deliver high quality services.

Graduate nurses will have options beyond traditional professional pathways and settings. There will need to be congruence between meeting the needs of patients, carers and communities; the demands of employers; and their own aspirations. Changing skill mixes and types of care delivery also need to be recognised, along with the need to support excellent learning within limited resources.

All these issues were considered at length in the development of the new pre-registration nursing education standards (NMC 2010a). They reflect an important shift of policy focus from the supply of NHS nurses to managing demand and skill mix.

Healthcare needs and public preferences

‘We should learn the lessons and plan what kind of workforce we really need. We need to understand the demographic and clinical challenges and the changing nature and scale of the needs, which are not going to be met by services as currently configured. There should be a massive rethinking and reconfiguration of the way health and social care is structured and delivered.’

This report has already explored future health needs and what the public and service users want from nurses (NMC 2010b). Although public preferences and healthcare needs are not an exact match, the NMC’s vision of the ideal nurse chimes with much current debate.

The NMC believes its new standards fulfil its mandate to safeguard the health and wellbeing of the public. Future needs have to be squared with current practice and the state of today’s workforce.

The image of nursing as a traditional, hospital-based, subordinate profession does not necessarily reflect reality. In fact nurses carry out an ever-widening range of interventions, sometimes as effectively as or better than doctors (Caird et al 2010). They work close to where people live and work, in community settings as well as hospitals. Yet the common perception is that nursing education is generally focused on the acute sector, and does too little to prepare nurses for working in primary health care.

‘There is a huge amount to be done to bolster understanding of the complexity of community nursing, valuing what they have to offer, and encouraging employers to see that the right thing is to invest and build that workforce - if only on the practical grounds that you have all this work coming out of the hospitals, you are going to be commissioned to deliver it, and you can’t deliver it with a very sparse workforce’ – Rosemary Cook, Queen’s Nursing Institute

The future workforce

The need to reassess the shape and skill mix of the workforce is a recurring message. Most submissions said nursing education should prepare nurses to manage care delivered by HCAs, as well as to nurse patients themselves – echoing the NMC view that ‘the core function of the nurse will always be caring. Nurses do not always provide care themselves; they also supervise others and delegate responsibility while remaining accountable for that care. They manage and lead teams of nurses and other professionals, to ensure that care is coordinated and consistent.

They teach others, including nursing students, and assess their competence' (NMC 2010b).

There is also wide agreement with the NMC view that while nurses in future will do many of the things they do now, the ways in which they work are already changing. Prescribing is a good example (Box 8). The shift to an all-graduate profession should be planned with consideration of levels of applicants, education capacity, and future workforce design. It has major implications for staff/skill mix and future nurse numbers.

Box 8: Responding to need: the nurse prescriber

The prescribing of medicines by nurses is an important, successful and expanding innovation to meet people's healthcare needs. Evaluations show that nurse prescribing provides better information to patients, increased access to medicines, and shorter waiting times.

It has been a long and difficult journey since the Cumberlege report, *Neighbourhood nursing: a focus for care*, recommended that community nurses should be able to prescribe, as part of their everyday nursing care, from a limited list of items (Department of Health and Social Security 1986). Endorsement of nurse prescribing in the first Crown report was an important step forward (Department of Health 1989), and was followed by the Medicinal Products: Prescription by Nurses etc. Act 1992.

Nurse prescribing has been a historic development for patients and the profession, and the UK model is being widely studied and adopted worldwide.

There is little point in moving to degree-level registration unless graduates are empowered and encouraged to work in different ways. Yet there is still no evolved, nationally agreed clinical/academic nursing structure that provides clarity about their roles and responsibilities in the multidisciplinary health and social care team and in preparing the current and future workforce. Unfavourable comparisons are made with the career structure of medicine, and the great disparity between the support (and related funding) offered to NQNs and junior doctors.

The lack of a career structure is closely linked with the ongoing failure to agree a way forward on recognition and regulation of advanced nursing practice. *'There is a real issue at specialist nursing level about academic qualifications. There ought to be clear academic standards if people are going to act at a specialist level, reflected in salary and status.'* As graduate nurses form an ever larger proportion of the registered nursing workforce, the need to grasp this nettle will intensify.

The other challenge is linked: how many graduate nurses will be needed to provide this highly specialised and adaptable resource? Many of the shortcomings of current education programmes, as related by our witnesses, stemmed from underfunding and over-rapid expansion of numbers in the last decade, leading to lack of capacity, shortage of suitable placements and other problems. HEIs in England told us it was hard to achieve their ambitions to deliver the new standards when dealing with sometimes dramatic increases in student intakes.

Skill mix and support worker regulation

'The skill mix has become unbalanced. The proportion of care assistants and nursing assistants

is probably too large, as cost efficiency models are pushing the system to have fewer leaders and more followers to save money. Then we have to ask: how well are they prepared for their roles? How well are they supervised and selected?'
– Jessica Corner, nurse dean

The commission heard widespread concern that skill mixes were being diluted by the expanding, uncontrolled use of non-registered and often untrained staff to carry out tasks previously the domain of registered nurses. Patients are often unaware of the level and qualifications of staff caring for them. These rapid, locally driven modifications in the shape and functions of the nursing workforce include valuable innovations, but are sometimes poorly implemented and not evaluated, raising serious concerns about public protection.

The commission finds it unacceptable that staff whose competence is not regulated or monitored are caring for vulnerable citizens, notwithstanding the significant challenges involved. It is equally unacceptable that registered nurses must take responsibility for supervising colleagues on whose competency they cannot rely. Our submissions showed strong support for appropriate skill mix, but also stressed the need to clarify staffing ratios, roles and responsibilities of different levels of staff.

In recent years there have been many calls for a national competency framework to end inconsistencies in standards, roles and responsibilities. Some work has been done. The NMC commissioned an independent scoping review in view of growing concerns that healthcare support workers (HCSW) were increasingly extending their role to undertake tasks previously undertaken by registered professionals, but remained unregulated. The review concluded that moving forward with

HCSW regulation would entail a large programme of work involving different groups of stakeholders, and advocated a holistic approach (Griffiths & Robinson 2010).

The approach remains piecemeal, but includes some promising initiatives:

- The Council for Healthcare Regulatory Excellence is developing a voluntary accreditation scheme, expected to start by the end of 2012.
- The Department of Health has commissioned Skills for Health and Skills for Care, the UK sector skills councils, to create a 'fit for purpose' code of conduct and minimum training standards.
- In Wales clear standards and competencies for HCSWs are linked to banding, a code of conduct and guidelines for delegation (National Leadership and Innovation Agency for Healthcare 2011). Academic study may be supported by courses that prepare people to 'launch to learning'.
- Scotland's code of conduct for HCSWs (NHS Scotland 2009) has been taken up by organizations to develop their own local codes (see, for example, Camden and Islington NHS Foundation Trust 2012).

Progression pathways enable and encourage some HCSWs to become nurses, using a skills escalator model. Foundation degrees - higher education qualifications that combine academic study with work-based learning, designed jointly by universities, colleges and employers - are already on offer for operating department assistants and others, and could create more opportunities for HCSW training.

Meaningful career pathways for support staff in bands 1-4 should be created, to encourage and reward talent and to avoid the cap on career progression that was a

major shortcoming of the old state enrolled nurse role.

Recommendations on the future nursing workforce

1. **Evidence of the positive impact of registered nurses on patient outcomes** must be utilised by healthcare providers in planning the nursing skill mix.
2. **Employers must make use of the enhanced skills of the emerging graduate nursing workforce**, as an opportunity to drive up standards and provide effective leadership and supervision of the clinical nursing workforce.
3. **Graduate nurses, as leaders of clinical teams, should supervise and delegate work to 'registered healthcare assistants' with clearly defined roles.**
4. **The numbers and roles of healthcare support workers who deliver patient care must be properly planned and regulated**, in the interests of patient safety and care quality.
5. **All staff at Agenda for Change bands 3-4 (and their equivalents outside the NHS) who deliver patient care should be trained to NVQ level 3 as the minimum UK standard**, delivered by healthcare providers and further education.
6. **A planned programme of regulation should begin with the mandatory registration of all staff who deliver patient care** at Agenda for Change bands 3-4 (and their equivalents outside the NHS) by an independent regulator.
7. **Governments, education institutions and employers**

must fulfil longstanding policy commitments to develop educational and employment models that widen access to nursing education, and provide career pathways for healthcare support workers including those who wish to train as nurses or midwives.

Theme 2: Degree-level registration

The move to degree-level registration is sometimes blamed for experiences of poor care. Some members of the public and some nurses - fuelled by sections of the media - fear that graduate nurses will be less compassionate and caring than nurses without degrees. It is claimed that the move will exclude potential nurses who are kind-hearted rather than clever.

Concern about the public perception of nursing was a key message to the commission. Some witnesses said the perceptions about graduate nurses stemmed from an outdated view of nursing, and a lack of understanding of its complexity. Many nurses feel that the move to an all-graduate nursing profession in the UK is a cause for celebration. They cannot understand why it attracts so much adverse comment. As they ask, what exactly is all the fuss about?

None of the evidence that the commission reviewed revealed any major shortcomings in nursing education that could be held directly responsible for poor practice or the perceived decline in standards of care. The commission saw no evidence to support the view that graduate nurses are less caring or competent than non-graduates, and indeed heard of evidence to the contrary.

As we have seen, the commission also heard compelling evidence of the positive outcomes of the earlier NMC standards. There is widespread agreement that the 2010 NMC standards seem generally fit for purpose and the framework is sound, though it is too early to make definitive judgements. The outcomes of the new programmes will not be known until 2015 at the earliest, and more large-scale evaluations will be needed.

How graduate nurses will be different

Most submissions said nursing must become a graduate profession to improve the quality of care and deliver and manage complex, skilled care in an increasingly fast-paced healthcare system. Nursing education programmes also needed to be sufficiently flexible to reflect differing short and long-term needs and expectations. Their values base needs to be nurtured, alongside critical thinking, problem-solving and interpersonal skills. This requires proficient scholarship, with the ability to understand and generate research and use its findings in practice, and to update skills and knowledge.

The commission's engagement with students revealed their clear understanding that acquiring critical thinking skills was just as vital as clinical skills. They strongly refuted the idea that having a degree in nursing was an obstacle to compassionate care. They explained how, when unsure of a clinical issue, they could refer to the relevant research and understand how it could inform and shape their practice. There was ample evidence of a mind-set of inquiry rather than unthinking acceptance of tradition.

Nursing students also told the commission how they were developing knowledge, skills and values for careers not only as clinicians, but also as leaders, teachers, managers and researchers.

Some submissions spoke of 'graduateness' as an important characteristic of the graduate nurse. This term attempts to capture generic qualities that might be expected of any graduate. There are additional demands on nursing students, who must meet the sometimes competing and conflicting requirements of the NMC, their university, and health service providers. Universities want the freedom to develop curriculums that reflect the autonomy and choice of degree-level programmes, while employers and commissioners who fund the programmes want them to be flexible and adaptable to local needs.

Submissions also highlighted the issues for nurses who qualified through the diploma route. RNs without degrees will of course continue to practise, and will comprise a decreasing proportion of the total number of RNs for the next 40 years. Some of these nurses have a sense of being 'left behind' and fear being undervalued. Many are already voluntarily topping up their education to degree level, often in their own time and at their own expense although some employers give good support.

Recruitment

Another set of concerns focused on recruitment for degree courses. Was the emphasis right, and were candidates selected for their academic ability over their ability to care? Were recruitment processes fit for purpose, or were they designed to meet targets in a competitive education market? Was there a risk of recruitment failing to reflect that diversity of the population?

As described earlier, historically large numbers of people are choosing to apply for nursing programmes, and the number of applications to nursing degree courses exceeds those to all other higher education courses. Competition for places at some universities is fierce. The

claim that degree courses deter suitable candidates therefore lacks substance: fortunately universities can recruit from a very large pool for academic ability as well as values. The media can be used effectively in recruitment: a recent television programme about Great Ormond Street Hospital for Children, London, played a significant part in applicants' choices.

Positive benefits to degree-level recruitment emerged in an evaluation by London South Bank University (Mealing & Curzio undated):

- the higher the nursing student's entry qualification level, the more likely they were to stay with the programme and exit with the highest academic achievement;
- students entering with GCSE-level entry qualifications struggled and were more likely to leave within the first year, but nearly half of those who stayed achieved a Level 6 qualification; and
- more students entering via an alternative access route appeared to leave in Year 2, and had the greatest percentage of Level 5 qualifications on exit.

The commission found clear support for recruitment processes that encompassed values-based assessment, academic achievement and ability, experience in a care setting and the motivation for choosing nursing as a career. It is vitally important to recruit students with values and resilience to work in complex health and social care contexts, and that students reflect the diversity of the communities they will serve. There should be strong emphasis on the quality and employability of graduate nurses as a key success and performance indicator.

Many examples of innovative good practice in recruitment were provided, and evidence from evaluations of selection strategies.

A recent study found that the predictors of student success in Northern Ireland (largely based on academic and practical achievements within the course) included higher academic admission scores; being female, older and not from an ethnic minority; good attendance; and previous nursing-related experience or knowing a nurse (Northern Ireland Practice and Education Council for Nursing and Midwifery 2011). There was limited evidence of predictive validity for successful completion of interviews, personal statements and autobiographical essays.

Nursing education has traditionally created social mobility, enabling women from working class backgrounds to have training and a career – nursing graduates are often still the first person in their family to get a degree. The current policy of ensuring a wide entry gate was strongly supported. Recruitment must come from a variety of routes, including a focus on mature access to encourage career changers as well as career starters, and attract candidates with caring experience. All currently registered nurses must be fully supported if they wish to obtain a relevant degree.

‘We do a lot of post registration upgrading and a lot of diploma nurses go on to do a degree. In the last few years the majority of them have got full funding, which really helped. My university is fully supporting students to top up’ – nursing lecturer

Courses that enable graduates from other disciplines (not only health-related) to become RNs while also gaining a master’s degree were commended to the commission. They attract students from a variety of backgrounds and disciplines, amid fears that they are under financial threat. A group of graduates taking a master’s degree leading to nursing registration described ‘enormous benefits’,

including the students’ breadth of knowledge and experience.

‘Students entering the postgraduate programme are in a position to learn, challenge, adapt to and invigorate working practices. Having given up other careers to enter this profession, we are able to demonstrate a commitment and eagerness to learn’ – group of graduate recruits to nursing

The nursing academic workforce

‘We now find ourselves in a very different institution to the one we signed up to. Most of the issues must be addressed at structural level by vice chancellors and departmental heads’ – professor of nursing

Degree preparation cannot succeed without an expert, motivated, well-rewarded academic workforce that is seen as a desirable career choice for graduate nurses. The commission heard surprisingly little about the nursing education workforce, but what it did hear was worrying.

The nursing academic workforce faces major challenges. These include its age profile, the low number of nurses leading academic departments, and the need to raise the bar in terms of the higher degrees required for senior academic nursing roles. The ‘dual career’ has an impact on the academic workforce, as universities expect to recruit staff with clinical experience and credibility as well as academic qualifications. Those academic nurses who undertake PhDs are the minority and often do it later in their career. Academic salaries have fallen behind comparable salaries in the NHS. Lecturers say research demands are difficult to reconcile with their large teaching workloads.

The Finch report devised a framework for developing clinical academic research capacity,

which when combined with the consultant nurse role goes some way to addressing the integration of practice, research and education roles (United Kingdom Clinical Research Collaboration 2007). Much more work is needed to ensure nursing academics are able to educate the new workforce, and to encourage more graduate nurses to choose a career path that encompasses teaching and research. Efforts are needed to raise expectations of academic attainment, and to provide better incentives and structures. Strategies are needed to accelerate academic/clinical career structures; attract high flyers into universities, perhaps in joint roles with practice; and address salary differentials.

Promising approaches

The All Wales Nursing and Midwifery Pre-Registration Group ensures a consistent approach, including the planned introduction of the new standards. It has produced standardized selection and recruitment principles, including a professional attitudes scale for recruitment.

Values assessment at the University of Worcester commences at recruitment and selection. Recruitment activities have been designed in partnership with occupational psychologists, provider partners and service users to identify the necessary and desirable characteristics. Selection is a tripartite decision between educators, practitioners and service users.

Kingston University and St George’s University, London and its NHS partners evaluated the introduction of a values-based recruitment process at the end of the first year (Perkins et al 2012). Acknowledging the limitations of traditional interviewing methods for assessing non-cognitive skills of empathy and ethical judgement, they found that the admissions policy for the

programmes was valid, but further refinement of the process was required to assess key qualities including honesty, integrity, compassion and respect.

The Student Personal Styles Questionnaire being developed by Cambridge Assessment, part of the University of Cambridge, is designed to provide relevant and objective information on candidates' non-academic, 'non-cognitive' personal qualities and skills. It is proposed that non-cognitive skills influence readiness to develop professional behaviours and motivation to care. Anglia Ruskin University's nursing courses are involved in the trialling.

The University of Southampton has developed a values-based curriculum for its new all-degree programme, based on a 'values based enquiry' model for learning and teaching. The model recognises that the professional values of care and compassion are not only central to nursing practice, but also provide intrinsic motivation for students to learn and progress.

Recommendations on degree-level registration

1. **The public needs to know what it can expect of registered nurses educated at degree level.** Stakeholders should scale up recruitment campaigns and other measures, including dialogue with the media, to promote better understanding of contemporary nursing and nursing education and dispel the myth that better educated nurses are less caring.
2. **Urgent action is needed to support the nursing academic workforce and guarantee its future quality:** halt the decline in numbers, raise morale, and attract new staff.

3. **A national clinical-academic career structure should be established,** to ensure time and opportunity to teach in care delivery settings as well as the classroom, support engagement in research focused on improving care, and ensure education is patient-centred. Incentives should be introduced for establishing joint university-healthcare provider roles.

4. **Greater investment is needed to strengthen the evidence base of pre-registration education.** High quality research should be commissioned through collaborative partnerships between universities that also engage service users and healthcare providers in systematic and rigorous evaluation to establish how education works well, where and for whom, and leads to the desired outcomes.

Theme 3: Learning to nurse

'The key to improving undergraduate programmes is a higher correlation of theory to practice to enable evidence-based care delivery in a holistic way, following the patient care pathway against a background of public health, primary care, secondary care and tertiary care'

Many submissions said the quality of the integration between service and education, to ensure robust, well supported, patient-centred learning, was crucial. At issue is the quality of the partnership, and how relationships between healthcare providers and universities are played out. Lack of good partnership between some NHS providers and HEIs in England has led to a loss of confidence, mistrust and uncertainty.

The 'uncoupling' of nursing education and practice that followed the move from hospital schools of nursing to universities may have weakened the practice-based aspects of teaching roles, according to a mixed-method study across four UK HEIs (O'Driscoll et al 2010).

Practice learning experiences, commonly called 'placements', were described in our literature review as key to successful programme outcomes. The 50-50 theory-practice allocation of learning time was widely supported, but the variable quality of the experiences was identified as a major problem.

The NMC provides extremely detailed guidance to support learning and assessment in practice (NMC 2008b, 2010a). HEIs and healthcare providers share the responsibility of providing opportunities and support for students. HEIs audit the practice learning environments - Wales has a useful standard tool - but the providers are responsible for their quality.

A review of curriculum evaluation across the UK, conducted as part of the major Scottish study (Lauder et al 2008), called for rigorous research into curriculum evaluation, both at the micro and macro level, which investigates content, process and outcome. *'There is a paucity of research in this area in the UK. Without such research, curriculum change will be uninformed'* - Roxburgh et al (2008)

Practice learning settings

'I qualified last summer in the adult nursing field after undertaking the degree. At the age of 54, I can honestly say the education in the university was very good and enjoyable. I was very much let down on my placements. I did not learn all the practical skills I should have' - Susan Barrett

The most successful learning experiences take place in positive practice environments, where high standards and good outcomes are achieved because organizational and individual learning are valued and encouraged. Investment in creating positive practice environments pays off by enhancing staff recruitment, retention and effectiveness, which leads to safer practice, better care and other cost benefits. The characteristics of such environments come as no surprise (Box 9) (Jarvis & Gibson 1997). Fifteen years on, this study precisely maps the areas where organizations often fall short.

Box 9: Characteristics of a good practice learning environment

- Effective links with the education institution;
- dedicated, uninterrupted time for group and individual learning sessions;
- use of the multidisciplinary team in teaching and assessment;
- adequate resources in the practice environment;
- staff who undertake research and involve learners; and
- dedicated staff who enable others to learn through a variety of processes, and have been adequately prepared to undertake roles as teachers and assessors.

The issue of the settings available for practice learning experiences loomed large in evidence to the commission, as did problems with mentorship. The main challenge is ensuring that NMC guidance is followed. Often it is not, for a variety of reasons including the following:

- The huge logistical challenge of finding placements for large numbers of students in the right place at the right time.
- The difficulty of identifying and

funding placements in community settings.

- The poor quality of some practice learning environments, including low standards of care, unwelcoming cultures and staff shortages.
- Weak partnership between programme providers.
- Lack of support for students while on placement.
- Lack of support for mentors.
- Inadequate resources, funding mechanisms and incentives.

The NMC requires students to acquire experience, knowledge and skills to deliver safe and effective care in a range of settings, including the community and non-NHS services (Weir-Hughes 2010). There are many criticisms, however, that they have insufficient preparation in non-acute settings outside hospital, including primary health care, public health and nursing homes.

The skill mix in the community is diluting the expertise available to meet demand (Queen's Nursing Institute 2011). In some places healthcare assistants are delivering elements of care in people's homes that would previously have been the province of an experienced community nurse. There are a third fewer district nurses, yet they are expected to be available to teach, mentor and look after students and NQNs.

Universities have tried to overcome the problems by setting up skills laboratories and simulated learning. Simulation and 'virtual placements' cannot substitute for practice learning in clinical settings, but can provide excellent complementary development of skills, knowledge and judgment, as our literature review confirmed.

'The importance of the practice environment as the driver of quality cannot be overestimated, not just of the patient outcomes and the staff's experience of work, but also of the

students' experience' – Anne Marie Rafferty, professor of nursing policy

Mentorship

'The erosion in the NHS of qualified staff and their replacement by other grades has resulted in many students being deprived of experienced teachers and mentors... Until this situation is halted there will remain a gap between the desire of students to learn to give compassionate and intelligent care, and the provision of care by well-meaning but inadequately prepared ancillary staff'
– Christine Chapman, emeritus professor of nursing

The role of the mentor is crucial in practice learning experiences. Discussion of what constitutes effective mentoring is plentiful (Chandan & Watts 2012). There is no unified international definition, but the NMC led the way by formalising the role and giving guidance (NMC 2008b). It defines a mentor as a registered nurse or midwife who, following successful completion of an approved preparation programme, is eligible to supervise and assess students in a practice setting. A sign-off mentor is a mentor who, having met additional NMC requirements, is able to judge whether a student has achieved the overall standards of competence required for entry to the register at the end of their programme.

This complex role requires support and training. Going beyond teaching knowledge and skills, it involves displaying and modelling leadership attributes. The mentor must be conscious of students' individual needs and requirements, and create an atmosphere conducive to learning (Ousey 2009). Positive role modelling and the opportunity for reflective practice are vital.

'The placement is as good as the mentor you have and as good

as the student you have, and the interaction between the mentor and the student' - nursing student

Students said their placement experiences were directly related to the quality of their mentorship. Mentors said that they and their students should learn from each other in a spirit of 'collaborative enquiry'. Both groups felt that mentors often had insufficient time to spend with students. Mentorship was demanding and the continuing dilution of skill mix meant a lack of high quality role models.

'A student can go through a three-year programme with absolutely minimal supervision and mentorship. I am on my management placement in my third week, and I have met with my mentor once officially. How do you protect that time in a clinical environment?' - nursing student

Effective mentorship requires investment in mentoring programmes, and in the quality of learning environments (Jokelainen et al 2011), but many healthcare providers currently fall short. Mentors complain of inadequate support from employers (workloads leave insufficient time for mentoring) and HEIs (lack of information about processes, learning outcomes and assessment).

Problems include lack of familiarity with programmes of study and documentation, few opportunities to update knowledge of or undertake training in supervision and assessment, and lack of familiarity with systems for training and assessment in the workplace (Hurley & Snowden 2008). Continuing ambiguities around the requirements of the role lead to organizational and professional conflicts.

Mentors are aware of their role and responsibility for the assessment of students in practice, according to a study from Northern Ireland

(Bennett 2011). However, some existing mentors may not have had the necessary preparation, skills and support to perform this role effectively.

'The expectation that mentors should be competent assessors of students in practice necessitates serious consideration to the ongoing support and education of both new and existing mentors' - Margaret Bennett, practice education facilitator

There was agreement that mentors should be selected for their knowledge, skills and motivation; highly valued and given a recognised status (some said equivalent to lecturers); and able to follow a clinical academic pathway. The foundations for mentoring can be laid at undergraduate level, with peer support and supervision.

Perspectives on good approaches to mentoring and the barriers to delivering them are plentiful, but more studies are needed of its effectiveness and outcomes in terms of skills, knowledge, positive placement experience and retention.

'Mentors need protected time with their students. We need to be able to say: "Give me an extra nurse to look after the patients so I can spend this hour with my student" - to make sure that in 10 years' time, when I have gone, the student replacing me will have my knowledge, my skills, my passion, my dedication and even my care' - nurse mentor

Leadership

'What you see in your role model mentors will live with you for life' - nursing student

The importance of strengthening nursing leadership through graduate nurses was often mentioned to the commission. It was felt they would help to improve leadership quality, and ensure the nursing voice

was more effective at board and commissioning level.

Students' exposure to skilled, positive leadership role-modelling was found to enhance the learning experience significantly in the research evidence. Providing access to leaders was problematic in provider organizations, particularly when nursing skill mix was diluted and nursing leadership weak.

Our rapid review of the nursing literature (2008-2012) explored approaches to developing leadership skills in pre-registration nursing education (Watts & Gordon 2012b). Using leadership skills, values and attitudes in practice was a key practical element of learning. Although there was no consensus on what constituted effective leadership, leadership skills were thought integral to the nursing role, and should be embedded throughout the programme rather than confined to a single module.

Reflective learning was recognised as both a leadership attribute, and a valuable learning technique that reinforced the blending of theoretical and applied learning. There are synergies with the development of emotional intelligence and leadership skills, although more understanding was needed of their relationship and how this might translate into learning programmes.

Many students learn leadership attributes from mentors. They include communication skills, problem-solving, identifying priorities, and using decision-making strategies (Ousey 2009). The experience of being mentored instils values and qualities used when they become mentors themselves (Pritchard & Gidman 2012). Their professionalism is strengthened, including the development of professional attributes and identity, and the attainment of professional competence.

Interprofessional education

'The evidence base indicates that pre-registration interprofessional education, when systematically planned and delivered, can modify attitudes and perceptions between professions, and heighten awareness of the need to improve practice through closer collaboration grounded in shared values, commitments and knowledge bases'
– Centre for the Advancement of Interprofessional Education

The commission agrees with the Centre for the Advancement of Interprofessional Education view on the importance of collaborative working (Centre for the Advancement of Interprofessional Education 2012). The future nursing workforce needs to be able to respond collaboratively to the complexity of problems presented by individuals, families and communities; manage relationships between the growing number of professions and their specialties resulting from medical and technological advance; and improve patient safety by improving communication and collaboration between professions.

Many previous reports have advocated multidisciplinary learning to help develop common approaches to quality assurance that will reduce duplication of effort. Healthcare professionals share many common values and need similar knowledge and skills in areas such as patient safety, ethics, research methods and record-keeping.

Nursing students therefore need effective interprofessional education (IPE) opportunities to become collaborative practitioners, and qualified staff should undergo IPE in their multidisciplinary teams. The opportunities for both are growing, and there is strong support for increasing collaborative opportunities for professions to

learn together (Pinfield et al 2011). Integrative working using clinical scenarios may be a productive way of increasing understanding of other roles, and preparing students for how care is delivered.

'Britain is a multicultural country and nurses must be able to provide clinically competent but also culturally competent and compassionate care. We should invest in multicultural team working for students, clinical teams and nurse educators' – Irena Papadopoulou, professor of transcultural health and nursing

Degree-level registration was finally creating a better platform for IPE, the commission heard from Jill MacLeod Clark, professor and previous dean of the faculty of health sciences at the University of Southampton. It made it possible to think seriously about a very innovative multidisciplinary programme where a lot of learning and material would be shared. *'A couple of universities are thinking about this, particularly for the shorter courses designed for students who are already graduates, where there may also be cohorts of graduate intake doctors and physiotherapists. That would be a good starting point'*, she said.

Possible solutions

There are some constructive partnerships between HEIs, health services, the public and other partners in Wales, Scotland and Northern Ireland, where national approaches have been agreed, and many examples of good practice in mentorship, supervision and preceptorship.

Nursing students found the organizations where they undertook service improvement projects receptive to their efforts (Christiansen et al 2010). Students reported increased confidence to undertake service

improvement, and perceived these capabilities as important to future career development and employment prospects.

Efforts are being made to create good learning experiences outside hospitals. A collaborative initiative between an HEI and a general practice introduced a link mentorship role to support and develop mentorship in district nursing settings (Gurling 2011). Kingston University and St George's University, London has a strategy to ensure that 50% of placements will be in community health and social care settings within three years. The University of Huddersfield is preparing nurses for future community roles through a programme entitled 'Primary Ambition,' which enables them to major in community placements.

There are many good examples of creative practice placement distribution across the UK. One initiative allocated students to short placements with nurse specialist teams, through an identified placement directory. This increased interprofessional and specialist learning opportunities, and capacity for placements (Pease & Kane 2010).

Many skilled mentors are working in effective learning environments, using established learning approaches directed to individual student learning styles. In many places they receive good support from employers and HEIs. Some HEIs and service providers have introduced awards for the best mentors, selected by students.

In Scotland, practice education facilitators in 100 centrally funded posts support mentors. They provide a valued bridge between practice areas and the HEI, boosted by their supernumerary status. Northern Ireland has established practice education teams across all five trusts and is evaluating their impact.

Students who challenge staff attitudes and knowledge during practice learning experiences help other students and staff (Williamson et al 2011). Peer-assisted learning supports workplace learning and the transition to clinical settings, and can reduce isolation and mitigate attrition (Christiansen & Bell 2010).

Recommendations on learning to nurse

1. **The quality of many practice learning experiences urgently needs improvement.** Learning to care in real-life settings lies at the heart of patient-centred education and learning to be a nurse.
2. **The NMC standards must be fully implemented through active partnerships** between NHS education and training boards at national and local levels, employers and universities, to ensure the quality of nursing education, and use and share existing tools and standards.
3. **Managers, mentors, practice education facilitators and academic staff must work together to help students relate theory to practice.** Close, effective collaboration between universities and practice settings should be enhanced through joint appointments.
4. **Employers and universities must together identify positive practice environments in a wide range of settings.** Many more placements must be made available in community settings, including general practice. The absence of funding to HEIs to support nursing students' practical learning experiences must be addressed.
5. **Employers must ensure mentors have dedicated**

time for mentorship, while universities should play their full part in training and updating mentors.

Mentors must be selected for their knowledge, skills and motivation; adequately prepared; well supported; and valued, with a recognised status.

6. **Practical learning must be underpinned with relevant knowledge from clinical and social science disciplines.** All students should be aware of the growing evidence base on good nursing practice. Graduate nurses, as future leaders of clinical teams, should understand how to evaluate, utilise and conduct research, and act on evidence to improve the quality of care.

Theme 4: Continuing professional development

Expectations of performance by newly qualified nurses are unrealistic. Medical students are not expected to be proficient when they qualify - they have a post-registration clinical career structure. Pioneering is needed to rethink expectations of the newly qualified nurse and create a post-registration pathway like medics' – nurse dean

The commission's terms of reference required it to consider what types of support for NQNs are needed to create and maintain a workforce of competent, compassionate nurses fit to deliver future health and social care services.

The NMC standards for pre-registration nursing education describe fully what the public can expect from NQNs (NMC 2010b)

(summarised in Box 10). The NMC sets the bar high: can NQNs actually meet these expectations, and do they receive the right support as they get into their professional stride? As stated earlier, there is some evidence that many NQNs already meet these high expectations (Lauder et al 2008).

Box 10: What the public can expect from a newly qualified nurse

All NQNs are safe and effective in assessing, planning, delivering and evaluating their practice (NMC 2012b). They also:

- Act to safeguard the public, making people their first concern, responsible and accountable for safe, compassionate, person-centred, evidence-based nursing care.
- Show professionalism, integrity and caring, working in partnership with people and their carers and other health and social care professionals and agencies.
- Have 'presence' through the energy and quality of their interaction, and communicate safely and effectively.
- Practise in a compassionate, respectful way, maintaining the dignity and wellbeing of all concerned. Decision-making must be person-focused.
- Demonstrate knowledge and understanding of how lifestyle, diversity and socioeconomic factors can affect health and illness.
- Be professionally accountable and use clinical governance processes to maintain and improve standards of care.
- Demonstrate the potential to develop further management and leadership skills during their preceptorship and beyond.

All nurses must be skilled in delivering essential care to all people including:

- eating, drinking, nutrition and hydration; comfort and sleep; moving and positioning; bowel and bladder care; skin health; wound management; infection prevention and control;
- clinical observation, assessment and decision-making; symptom management; end of life and palliative care; risk management; medicines management; information management;
- communication; emotional support; a commitment to equality, diversity, inclusiveness and rights.

We were repeatedly told that pre-registration nursing education should be regarded as just the beginning of a process of lifelong learning and development. NQNs have completed a demanding undergraduate programme and various assessments of their competence, but cannot be 'the complete package'. Continuing professional development (CPD) is essential, including positive role modelling and the opportunity for reflective practice.

An estimated 85% of NQNs work in the NHS. Many issues impact on their ability to deliver good care and to develop themselves. The commission heard much about the culture of provider organizations; the absence of developed career pathways for them; and inadequate opportunities for CPD, including preceptorship and interprofessional learning, in some organizations.

Lack of CPD, and inadequate career structures and prospects, will not attract or retain graduate nurses,

and will reduce clinicians' ability to care, mentor, teach, lead and conduct clinical research. Fears were expressed about signs of disinvestment in CPD. Professional development budgets - already low in nursing - are an easy target for savings, and innovative approaches were needed. *'A lot of nurses are abandoned after 18 months or two years - we are not interested in you any more, you are just a workforce, get on with it.'*

CPD was seen as integrally linked not only to providing high quality care but also to retaining staff. High wastage has long been a feature of the RN workforce. In 2010-11, nearly 29,000 nurses, midwives and health visitors left the NHS in England, an outflow of around 6% excluding retirements. Although economic hardship may lower wastage, submissions said urgent attention was needed to keep and motivate staff.

Preceptorship

The NMC defines preceptorship as 'the support and guidance that enables qualified nurses to make the transition from being a student to becoming a more confident practitioner to practise in line with NMC standards' (NMC 2006). A preceptor is an RN 'who helps NQNs develop confidence and reinforce their knowledge and skills after their initial registration'.

The commission conducted a rapid review of studies of NQN preceptorship programmes from 2008 to 2012 (Currie & Watts 2012). The mutual benefits of preceptorship programmes for NQNs, preceptors and organizations were well described, though there was little scientific evaluation of their effectiveness. Preparatory training for the preceptor role in the UK was less widespread than in other countries.

The transition from student to staff nurse creates a period of uncertainty, with new responsibilities and accountabilities being a source of stress and pressure (Higgins et al 2010). Preceptorship helped to address this, but provision was variable, and NQNs reported frustration and demoralisation in not being able to deliver care to their expected standards.

Maintaining the positive aspects of preceptorship required organizational commitment including workload planning, dedicated time, and training, preparation and ongoing support for nurses acting as preceptors (Robinson & Griffiths 2009). A range of organizational systems were needed to provide formal programmes, including training and ongoing support for preceptors and closer collaboration between HEIs and healthcare providers.

The review concluded that the low priority some organizations gave to preceptorship was influenced by their lack of understanding of its value, and the absence of regulatory and professional consensus on best practice.

Although the NMC published guidance on preceptorship in 2006, there has been little systemic growth in the provision of programmes, apparently partly due to a lack of consensus between regulatory and professional bodies - making it difficult to convince holders of education and training budgets of its value (Davies & Mason 2009).

Submissions gave unanimous support to the need to promote preceptorship. The recommendations of the Association of Chief Children's Nurses/Child Health Academic Community echoed many others. They called for exposure of students and NQNs to senior nurses, to gain understanding of job roles, career

pathways/progression and access to inspirational role models and leaders. They advocated preceptorship programmes and in-house training for staff supervising NQNs, and a post-qualification period of consolidation similar to the system for doctors.

Others also made this comparison with medicine. Medicine provides a good model in that newly qualified doctors are not seen as ‘the complete package’. They follow structured career pathways, including a well funded two-year postgraduate foundation training programme to form the bridge between medical school and specialist/general practice. Furthermore, the career structures in medicine include clinical academic posts at various levels, which enable effective clinical/ academic partnerships to drive innovation and research.

Preceptorship in community nursing was highlighted as a particular problem, with the lone working aspects of the role. Frequent management upheavals and a high turnover of senior nurses meant community nursing leadership had been weakened in many areas, with a negative impact on the quality and provision of preceptorship. In an RCN Congress debate in 2012, Sharon Tappin said working in an acute setting was inadequate preparation for a community role, but questioned whether there were enough experienced preceptors. The challenges were similar across the UK. For example, the RCN in Northern Ireland reported that preceptorship needed to be better developed in the community.

Possible solutions

The UK-wide approach to modernising nursing careers (Department of Health 2006) has stimulated valuable work on nursing career paths.

Some trusts invest strongly in training their workforce. Napier University and NHS Lothian have a joint Leadership in Compassionate Care programme. It includes a strand on supporting NQNs during their first year in practice, to facilitate the transition from student to competent and compassionate staff nurse.

Flying Start, developed in Scotland and now rolled out to England, is a national on-line development programme that supports all NQNs and other professionals joining the NHS during their first year of practice.

Four Seasons Health Care and the Huntercombe Group, a leading independent sector provider of nursing homes and care homes, employs 5000 RNs on 500 UK sites. Recognising the importance of ‘person-centred workforce development’, it has set up an assessment centre for NQNs and gives them a structured progression through preceptorship, qualification as a mentor and other options. In Northern Ireland, its preceptorship programme developed jointly with the RCN resulted in nearly 300 nurses becoming permanent Four Seasons employees.

At the University of Nottingham, interprofessional practice learning teams provide well-evaluated opportunities for all registered professionals in practice settings to support other healthcare students, and a framework for students from different professional courses to learn from each other.

Recommendations on continuing professional development

1. **A national nursing career framework must be implemented urgently by all partners and properly resourced.** It should be based on the four governments’ existing policies of building career

frameworks and pathways that support movement between, and synthesis of, practice, management, education and research; that value and reward different career paths; and that attract and retain high quality recruits.

2. **Employers, universities, regulatory bodies and royal colleges should recognise, fund, promote and support nurses’ continuing professional development** at appropriate and equitable levels as an investment for the future.
3. **The NMC requirement that newly qualified nurses undergo a post-qualification ‘preceptorship’ period of consolidation must be fully implemented** to promote safe, high quality care.
4. **Interprofessional learning must play a key role** in continuing professional development. Training professionals in teams must also have a much stronger focus in pre-registration nursing education.

Theme 5: Patient and public involvement in nursing education

‘People who are living with the conditions are the experts. I might come along as a clinician with a set of skills and some knowledge, but the real expert is the person’ – Vicki Matthews, specialist nurse advisor, Multiple Sclerosis Trust

The best health care is focused on the specific needs of service users and their carers and families. They are becoming much

more knowledgeable about their conditions, and what keeps them healthy. Many want to be more involved in care planning and decision-making.

Good patient and public involvement in the development, delivery and review of nursing education is an important aspect of this. It is important to value the people who want to be involved and ensure that they are real partners in the process, and not simply pay lip service to the idea.

The 2010 NMC standards took the important step of requiring that education providers must clearly show how users and carers contribute to programme design and delivery (NMC standards for education, requirement 5.1.2). This contribution can take many forms. The commission found high awareness of these standards, and much evidence of growing patient and public involvement in the following:

- recruitment and selection;
- co-production of curricula;
- delivery of some sessions, especially when teaching communication and compassion issues;
- practice learning experiences and simulations;
- student assessment; and
- policy development.

This was a relatively new and challenging concept for most HEIs, and for their service provider partners. Academic staff needed training to work with service users in a meaningful way, and the NHS was thought to be a hierarchal and patriarchal structure, still task-driven rather than patient-driven. However, the commission learned of excellent initiatives where patient groups are embedded in the process, enriching curriculum development and implementation. Patients and user organizations welcomed the involvement and stressed the need to increase it. There were many

examples of progress, but much more to do.

User involvement varies widely, according to research from Swansea University (Terry 2011). Julia Terry visited 15 universities in the UK and Ireland in search of best practice methods that support and prepare people for service user involvement activities in nursing education. She identified essential processes in the cycle of user involvement, including ongoing recruitment, access to resources and senior management support. Swansea's College of Human and Health Sciences is implementing her recommendations (Swansea University College of Human and Health Sciences 2012).

'As this is new territory, we may not know all the challenges at the outset. There will be challenges as staff may not be clear about the values and principles of service user involvement, or the transparent approach that is needed' – user and carer involvement group, Swansea University

There were different approaches to recruitment and selection of students. Some HEIs had ongoing relationships with patients' organizations, and involved service users actively in interviewing applicants. Others took their recruitment tools to service user groups for critical review. The Open University involves service users in developing a 'writing task' as part of the application process (for 2012-13 the theme was 'the meaning of empathy').

Service users could find these experiences fulfilling. *'I found the day to be enjoyable. Even though the sessions focused primarily on assessing how students work in a group environment, I believe prospective candidates appeared more relaxed and at ease in their surroundings,'* said a service user from Swansea after her first experience interviewing.

The commission heard examples of how service users helped to write curriculums, were thoroughly integrated in the two-year process, and attended validation events. They were also involved in delivering some sessions, especially when teaching communication and compassion issues, in practice learning experiences and simulations. They often participated in simulated scenarios, playing the patient role and giving students feedback on what it felt like.

In one project students used videoconferencing to observe a clinic group education session about initiation of insulin (Walsh et al 2010). They said it helped them link theory to practice, and gave them a better understanding of diabetes from the perspective of the person with the condition or their carer. Elsewhere, digital stories combining personal narratives, images and music are increasingly used to tell emotional stories of patient care (Christiansen 2011).

'Some of our third year students worked alongside patients to develop part of the patient and public involvement strategy for that particular service, and report it back to the chief executive and team. That made a big difference, developing their questioning and evidence base to take that forward with confidence into the workplace post qualification' – nurse lecturer

Service users were increasingly involved in assessment of students, acknowledging that this had to be carefully monitored if they were unwell and receiving care.

Other practical difficulties included identifying suitable volunteers and arranging payment of fees and expenses. One HEI said it paid all service users a visiting lecturer rate. Many service users with long-term conditions receive welfare benefits that might be jeopardised by such payments, however.

'We value and will be incorporating responses from service users, for instance about students' attitudes towards dignity, compassion and so forth in terms of professional values, which are very high in the NMC standards' – nursing dean

Formal evaluation of patient and public involvement was less evident. One study described a patient-driven approach to evaluation (Roberts et al 2010). Lay involvement assistants were recruited and trained to develop and evaluate the contribution of lay people to pre-registration recruitment, and met applicants before their normal selection interview to provide an independent viewpoint. The pilot project gained favourable feedback from candidates and lay participants.

Less directly addressed in the submissions, but implicit in much discussion about future health care and in the way curriculums were developed and taught, was the need for nurses to share skills and knowledge with patients and families. They are co-producers of health and, outside hospitals, usually the main carers. This move to a new professional paradigm and non-hierarchical relationships should be addressed during pre-registration education.

Possible solutions

Several HEIs provided impressive evidence of comprehensive, strategic and system-wide patient and public involvement in nursing education.

Kingston University and St George's University, London, has a strong track record in public engagement in education and research. It established a Service User and Carer Consultative Forum in 2002 and appointed an honorary fellow in public and patient engagement to provide advice and guidance to strategy development. Its curriculum and learning outcomes were developed in partnership with

commissioners, service providers and service users.

Service users and carers are supported and developed to engage in interviewing applicants, and are actively engaged in programme delivery. They are fully integrated in the teaching teams for the modules that call on their expertise, experience and perspective on patient safety. Development days are offered to encourage engagement and provide support for their contributions.

The University of Huddersfield facilitates ongoing relationships with service users and carers, who are involved in interviews, selection and delivery of the programme. They engage with students on issues related to the values and the need for dignified and compassionate care. The engagement of service users and carers in curriculum development showed an open and inclusive approach to partnership, which enriched the programme.

Buckinghamshire New University integrates service user involvement throughout the student 'journey', starting with recruitment. Representatives from People's Voices are regular members of interview panels, participate in simulated learning activities and contribute to teaching sessions.

Recommendations on patient and public involvement

- 1. The NMC standards on patient and public involvement in pre-registration nursing education must be fully implemented**, as a vital step in putting the experiences of patients and the public at the heart of nursing education.
- 2. Local education and training boards (and their equivalents), healthcare providers and universities**

should jointly deliver a comprehensive, strategic and transparent approach to patient and public involvement in pre-registration nursing education. It should encompass training and rewards for service users and carers, and development for academic and clinical staff so they can work with service users in a meaningful way.

- 3. Healthcare providers must actively promote and support patient and public involvement in nursing education** through their patient experience strategies, education strategies and board-level quality assurance processes.

Theme 6: Infrastructure

The commission heard about a range of issues relating to different aspects of the infrastructure of nursing education. Many concerned regulation and funding. Funding concerns the purchasing of education, and regulation concerns its planning, delivery and scrutiny; both are considered here as essential underpinnings for the success of pre-registration nursing education.

Regulation

The regulatory landscape relating to both health services and higher education is highly complex, and even more so where they intersect in matters that influence the education of health professionals, as described in Part 2.

The commission heard little specific criticism of the complex and detailed NMC regulation processes, but much concern about duplication. Kingston University and St George's, University of London, at the request of Lord Willis, reviewed

the NMC audit process of approved programmes and the NHS London enhanced contract performance monitoring process, to compare their requirements for evidence (Gale et al 2012). There were many areas of duplication:

- literacy and numeracy skills;
- recruitment and selection processes that include stakeholders, including service users, placement providers and students;
- criminal records checks;
- health screening processes;
- monitoring and development of professional attributes; and
- use of student feedback to enhance programmes of study.

Some standardisation is desirable across all bodies that perform quality audits of health and social care education programmes, the review concluded. The results should be publicly available, open to scrutiny and joined up. Importantly, this coordination of reporting to stakeholders would reduce duplication and improve the quality of evidence provided to support compliance with expectations of providing the best.

A number of submissions deplored the plethora of regulatory systems – the difficulty in identifying who does what, the workload they generate, and the lack of cooperation between them. The amount and scope of regulation generates much comment on the difficulties of compliance, and on the lack of harmonization and cooperation between regulators. This puts a large regulatory burden on healthcare employers and HEIs.

Uncertainty also prevails about the role and shape of regulation in the reformed NHS as well as in higher education. The performance of the NMC and CQC in particular has been subject to much adverse criticism, and there are fears of further duplication with the introduction of

the national Education Outcomes Framework in England in 2013-14.

For all the plethora of regulation, one area was raised that appears to be poorly regulated – the culture of the workplace. Poor practice environments have a negative impact not only on the quality of care, but on student learning, mentorship and preceptorship.

An independent reference group of six leading nurses highlighted to the commission the key role of the ward sister and community team leader in establishing an ‘enriched’ environment for staff, where they and their clinical leaders feel valued and supported. The challenge is how to gauge whether an organization is successfully fostering a culture that enables this kind of enriched environment. The group has developed a simple tool, a ‘cultural barometer’ that is being piloted by the National Nursing Research Unit at King’s College London in NHS trusts, and funded by NHS London (Emerton et al 2012). It aims to be useful and meaningful, with a minimal bureaucratic burden, and complementary to existing regulation and inspection frameworks.

In another promising development, some HEIs are placing greater emphasis on safeguarding by discussing CQC outcomes with students, and teaching them how to observe for dignity, nutrition and appropriate communication with patients. Colleagues in Wales are learning from the CQC experience in England, and a Scottish university is using CQC outcomes and problem-solving as a learning tool.

Funding

‘The continuation of investment in education is the policy that needs to roll forward. It is not that we have any lack of solutions to any of these problems; all the solutions are in our grasp’ – Anne Marie Rafferty, professor of nursing policy

Like its regulatory infrastructure, the funding of nursing education is extremely complex, as described in Part 2. It accounts for a large chunk of public spending.

Submissions and witnesses raised concerns about the inequitable levels and mechanisms of funding for nursing education. Unfavourable comparisons were often made with funding for medical education. In particular there were complaints about inadequate mechanisms and resources for funding practice learning experiences. The lack of financial incentives was seen as a major issue, and the way in which funding was allocated was said not to support best outcomes.

Adequate and targeted funding was critical to increasing the number of placements in general practice, community and other areas. It was suggested that commissioners should ring-fence funds for community-based programmes.

There was support for the government’s commitment to the principle of tariffs for education and training as the foundation of a transparent funding regime that will support ‘a level playing field between providers and professions’. Funding needs to follow the student, both at university and in practice. Who would hold the purse strings? Some argued for the universities, but with some funds going to healthcare providers to invest in their learning environments. It was said either model would work, as long as the money was ring-fenced and spent for that student.

The move to an all-graduate nursing profession inevitably raises questions about financial support for students, and in particular the future use of bursaries to support mature students, who perform particularly well in studies of programme outcomes. The bursary system is different in each UK country. The commission believes there should

be a long-term, secure financial system throughout the UK to support pre-registration students that does not inhibit the recruitment through access routes of mature students.

People who choose nursing as a second career may not be able to access funding to train. Under current rules only one student loan is permitted, which means that nursing students who are already graduates may not be able to afford to study nursing once bursaries are reduced. This is already impacting on the provision of fast-track courses for graduates despite the high quality of the recruits.

The draft Care and Support Bill (Secretary of State for Health 2012), among other important matters, covers the establishment and functions of Health Education England. It offers a vital opportunity to improve workforce planning and education commissioning in England. The Commission urges that the Bill support the following principles and actions:

- Adequate and transparent funding mechanisms and allocations for basic and continuing education for nurses.
- Long-term development and planning of the healthcare workforce, including recognition of nursing as a UK-wide resource.
- Improving data and information for workforce planning.

Recommendations on the infrastructure

1. The regulation and inspection of the many organizations and settings where nursing education is delivered should be streamlined and better integrated

to increase effectiveness and reduce the heavy audit burden. Healthcare and education regulators should work in close partnership, and take full heed of each other's findings. Their

processes should be streamlined and duplication reduced.

2. The culture of healthcare provider organizations should be routinely assessed, building on ongoing work to develop and standardise a 'cultural barometer' that will help their boards ensure that practice settings are suitable learning environments.

3. Pre and post-registration nursing education must have equitable access to resources through introducing a level playing field and fair funding mechanisms to end the wide disparities between the overall funding of different health professions' education. Sustainable funding is essential to ensure effective mentorship and support placements in community settings.

4. A long-term, sustainable funding model should be developed across the UK to support the education and training of future nurses, including adequate financial support for students and bursaries to support mature students.

5. The four UK governments should include pre-registration nursing programmes in future allocations of the service increment for teaching (SIFT) and its equivalents.

This is vital to improve the quality of nursing students' practical learning experiences, especially in community settings where many will work in future.

Part 5: Conclusions and recommendations

The commission's central concern was to encourage high quality patient-centred care – delivering the best health outcomes for patients and populations through the best nursing. The education of nurses and other health professionals is not an end in itself, but a means to help people achieve better health, a better quality of life or a dignified death. We therefore sought to address how the relationship between health need, health policy and the education of nurses could be strengthened.

The commission was left in no doubt about the great importance of nursing education in enabling high quality care, and the number of stakeholders who have an interest in it: patients, families, carers and the public above all. Concerns about quality dominate current public, professional, and policy discourses about nursing – the satirical magazine *Private Eye* even runs cartoons called *Fallen Angels*.

Such concerns are not new. A long series of inquiry reports from the late 1960s to the present has made stringent criticisms of nurses, doctors, managers, policy-makers and others. 'The consistent patterns of failure are striking' (Walshe 2003) and countless recommendations have been made over the years – often repeating previous ones – but many if not most are not implemented effectively.

There is a tendency to view the past as a golden age for health care (often around the 1950s), reinforced by popular nurse memoirs and television dramas. Yet there is much evidence to the contrary – overall health and life expectancy are better than ever, though of course attributable to improvements in the social determinants of health as well as to better care.

The move to degree-level nursing registration has become a lightning conductor for disquiet, offering a simplistic and erroneous explanation

for a complex social phenomenon. The irrational idea that kindness and intelligence are incompatible is not applied to other all-graduate health professions such as midwifery and physiotherapy. Anxiety among patients and the public – regularly fuelled by sections of the media – that graduate nurses will be less compassionate and caring than nurses without degrees provides a turbulent backdrop to the many unresolved challenges facing nursing education today.

The commission found no evidence of any major shortcomings in nursing education that could be held directly responsible for poor practice. It also found it difficult to prove or disprove the perception of a decline in standards of care. Data on cases of professional misconduct by nurses and other health professionals, for example, have not been fully analysed to compare rates and trends.

This is not in any way to understate or deny unacceptable care, but an understanding of the context is vital so that it can be better understood and thus more effectively tackled.

The evidence outlined earlier in fact associates well qualified nurses with improved patient, nurse and financial outcomes; a direct correlation between poorer care a lower proportion of registered nurses in the skill mix; and the economic value of well qualified and effectively deployed nurses. The best-staffed healthcare providers have significantly lower mortality rates and reduced risk of complications.

The move to degree-level registration of all newly qualified nurses in England is actually a further step in a very long process that brings England into line with the rest of the UK and much of Europe. It is over 50 years since the University of Edinburgh launched the first bachelor's degree in nursing in the

UK. A growing number of nurses – well over a third – already hold a qualification at bachelor's degree level or above. All the health and social care professionals with whom nurses work are already educated to degree level, so nurses will at last be fully prepared to work as equals in multiprofessional teams – to analyse and present evidence, reflect on and challenge practice, take part in improvement projects and provide leadership.

Rather than questioning the validity of this change, it may be asked why it took so long for well-founded recommendations of prescient reports like that of the 1972 Briggs committee to be adopted. The underlying question is why moves to upgrade nursing education, now and for many years past, appear routinely to provoke concerns that newly qualified nurses are not fit for practice – despite the lack of supporting evidence.

Project 2000 is often blamed for supposed failures of nursing education, but a more considered view is that healthcare providers were not ready to welcome or help deliver this visionary model of education and its practitioners. In many ways it prefigures today's new NMC model. Will the same be said of that? The NMC standards must be given breathing space to bed down and to be evaluated, as education and service providers grapple with them alongside many other challenges. The question is how they will be interpreted and upheld by healthcare and education providers.

Pre-registration education is in any case not the only or even the main driver of high quality nursing. This report has highlighted other issues more pertinent to the quality of care, including the culture of the organizations where students and new graduates work; inadequate or outdated service models; the lack of proper career pathways and continuing professional development

for nurses; inadequate preparation and regulation of healthcare support workers; and faulty mechanisms for planning, commissioning, funding and regulating nursing education.

As urged in many previous reports, closer partnerships of many kinds are needed to tackle issues that are wrongly attributed to education shortcomings. This means going against the tide of a climate that is fostering competition rather than cooperation. Better partnerships and more joint working are required between regulators; all service providers including the NHS, social services, third sector and private organizations; nursing faculties, medical schools and other health professional education institutions; and service users, carers and public representatives and organizations. All must 'get a grip', as we were told, on education standards and provision in their organizations. They must strengthen education governance, discuss the issues regularly, and act on the outcomes.

The lack of research on the outcomes of nursing education is a major concern, especially considering its very large costs and the importance of high quality care. Too little funding is allocated to this type of research. There are many gaps in the evidence, and a need for more high-quality systematic studies.

Nursing leaders should step up to the plate and develop a collective narrative about the contribution of academic nursing to the quality of care. University leaders, and not just nursing deans, should value nursing as a practice discipline and recognize its contribution to their agenda for community and employer engagement.

Staff shortages, financial constraints and the constantly rising pressure of patient demand and need are making nurses' work ever harder, and they say the constant barrage of criticism is sapping their morale.

In 2011, compared with 2009, survey results show that fewer nurses are enthusiastic about their work, feel it is a rewarding career, or would recommend it as a career (Trehitt & Glenn 2011). It is in everyone's interest to change this unhelpful mood music, in the spirit of appreciative inquiry rather than criticism and blame.

Finally, the commission was enthused by the enormous dedication, intellect and altruism that shone through the submissions, witnesses, meetings and site visits. They were left in no doubt of the enormous and often unsung efforts of nurses at all levels and in all settings to provide the best possible education that produces high quality care.

Above all we were inspired by nursing students. Their bright ideas, commitment and compassion left no doubt that degree-level registration is the right way to go. Valuing students and making them partners in education and practice is key. They should be empowered to lead the way in shaping nursing education and practice for the future. This is a great story to tell and sell.

'The status of nursing has to be restored at management level from the ward to the board. This requires a culture change that can only be earned by gaining respect for the quality of care being delivered' - Audrey Emerton, nurse and member of the House of Lords

'At the heart of high quality pre-registration nursing education is the partnership between higher education institutions and service; excellent education depends on the quality of this partnership at every stage of the student nurse's preparation' - Council of Deans of Health

'Nurses and nursing are at the heart of the delivery of safe, effective and compassionate care, not only as practitioners but also as clinical leaders, and champions of improvement. It is essential that pre-registration nursing education prepare the future workforce for a very different world' - Malcolm Grant, Chairman, NHS Commissioning Board Authority

'I feel privileged to be a nursing student, joining a dedicated and worthwhile profession. I hope my training will enable me to give good care to many children and families in the future' - Melanie Patterson, third year nursing student

Recommendations

Theme 1: The future nursing workforce

- Evidence of the positive impact of registered nurses on patient outcomes** must be utilised by healthcare providers in planning the nursing skill mix.
- Employers must make use of the enhanced skills of the emerging graduate nursing workforce**, as an opportunity to drive up standards and provide effective leadership and supervision of the clinical nursing workforce.
- Graduate nurses, as leaders of clinical teams, should supervise and delegate work to ‘registered healthcare assistants’ with clearly defined roles.**
- The numbers and roles of healthcare support workers who deliver patient care must be properly planned and regulated**, in the interests of patient safety and care quality.
- All staff at Agenda for Change bands 3-4 (and their equivalents outside the NHS) who deliver patient care should be trained to NVQ level 3 as the minimum UK standard**, delivered by healthcare providers and further education.
- A planned programme of regulation should begin with the mandatory registration of all staff who deliver patient care** at Agenda for Change bands 3-4 (and their equivalents outside the NHS) by an independent regulator.
- Governments, education institutions and employers must fulfil longstanding policy commitments to**

develop educational and employment models that widen access to nursing education, and provide career pathways for healthcare support workers including those who wish to train as nurses or midwives.

Theme 2: Degree-level registration

- The public needs to know what it can expect of registered nurses educated at degree level.** Stakeholders should scale up recruitment campaigns and other measures, including dialogue with the media, to promote better understanding of contemporary nursing and nursing education and dispel the myth that better educated nurses are less caring.
- Urgent action is needed to support the nursing academic workforce and guarantee its future quality:** halt the decline in numbers, raise morale, and attract new staff.
- A national clinical-academic career structure should be established**, to ensure time and opportunity to teach in care delivery settings as well as the classroom, support engagement in research focused on improving care, and ensure education is patient-centred. Incentives should be introduced for establishing joint university-healthcare provider roles.
- Greater investment is needed to strengthen the evidence base of pre-registration education.** High quality research should be commissioned through collaborative partnerships between universities that also engage service users and healthcare providers in systematic and rigorous evaluation to establish how education works well, where and for whom, and leads to the desired outcomes.

Theme 3: Learning to nurse

- The quality of many practice learning experiences urgently needs improvement.** Learning to care in real-life settings lies at the heart of patient-centred education and learning to be a nurse.
- The NMC standards must be fully implemented through active partnerships** between NHS education and training boards at national and local levels, employers and universities, to ensure the quality of nursing education, and use and share existing tools and standards.
- Managers, mentors, practice education facilitators and academic staff must work together to help students relate theory to practice.** Close, effective collaboration between universities and practice settings should be enhanced through joint appointments.
- Employers and universities must together identify positive practice environments in a wide range of settings.** Many more placements must be made available in community settings, including general practice. The absence of funding to HEIs to support nursing students’ practical learning experiences must be addressed.
- Employers must ensure mentors have dedicated time for mentorship, while universities should play their full part in training and updating mentors.** Mentors must be selected for their knowledge, skills and motivation; adequately prepared; well supported; and valued, with a recognised status.
- Practical learning must be underpinned with relevant**

knowledge from clinical and social science disciplines. All students should be aware of the growing evidence base on good nursing practice. Graduate nurses, as future leaders of clinical teams, should understand how to evaluate, utilise and conduct research, and act on evidence to improve the quality of care.

Theme 4: Continuing professional development

- 1. A national nursing career framework must be implemented urgently by all partners and properly resourced.** It should be based on the four governments' existing policies of building career frameworks and pathways that support movement between, and synthesis of, practice, management, education and research; that value and reward different career paths; and that attract and retain high quality recruits.
- 2. Employers, universities, regulatory bodies and royal colleges should recognise, fund, promote and support nurses' continuing professional development** at appropriate and equitable levels as an investment for the future.
- 3. The NMC requirement that newly qualified nurses undergo a post-qualification 'preceptorship' period of consolidation must be fully implemented** to promote safe, high quality care.
- 4. Interprofessional learning must play a key role** in continuing professional development. Training professionals in teams must also have a much stronger focus in pre-registration nursing education.

Theme 5: Patient and public involvement in nursing education

- 1. The NMC standards on patient and public involvement in pre-registration nursing education must be fully implemented,** as a vital step in putting the experiences of patients and the public at the heart of nursing education.
- 2. Local education and training boards (and their equivalents), healthcare providers and universities should jointly deliver a comprehensive, strategic and transparent approach to patient and public involvement in pre-registration nursing education.** It should encompass training and rewards for service users and carers, and development for academic and clinical staff so they can work with service users in a meaningful way.
- 3. Healthcare providers must actively promote and support patient and public involvement in nursing education** through their patient experience strategies, education strategies and board-level quality assurance processes.

Theme 6: Infrastructure

- 1. The regulation and inspection of the many organizations and settings where nursing education is delivered should be streamlined and better integrated** to increase effectiveness and reduce the heavy audit burden. Healthcare and education regulators should work in close partnership, and take full heed of each other's findings. Their processes should be streamlined and duplication reduced.

- 2. The culture of healthcare provider organizations should be routinely assessed,** building on ongoing work to develop and standardise a 'cultural barometer' that will help their boards ensure that practice settings are suitable learning environments.
- 3. Pre and post-registration nursing education must have equitable access to resources** through introducing a level playing field and fair funding mechanisms to end the wide disparities between the overall funding of different health professions' education. Sustainable funding is essential to ensure effective mentorship and support placements in community settings.
- 4. A long-term, sustainable funding model should be developed across the UK to support the education and training of future nurses,** including adequate financial support for students and bursaries to support mature students.
- 5. The four UK governments should include pre-registration nursing programmes in future allocations of the service increment for teaching (SIFT) and its equivalents.** This is vital to improve the quality of nursing students' practical learning experiences, especially in community settings where many will work in future.

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Appendices

Appendix 1: About the Commission

Chairman

Lord Willis of Knaresborough

Panel

Sheila Dilks, executive director of transformation, West Cheshire Clinical Commissioning Group

Jill Evans, senior education and development manager, Aneurin Bevan Health Board

Glynis Henry, chief executive, Northern Ireland Practice and Education Council for Nursing and Midwifery

Sharon Northeast, Patient Voices representative

Subo Shanmuganathan, head of learning and development, Macmillan Cancer Support

Margaret Smith, dean, School of Nursing and Midwifery, University of Dundee

Veronica Snow, lead professional, South West Wales Cancer Network

Expert advisers

James Buchan, professor, School of Health, Queen Margaret University, Edinburgh

Baroness Cumberlege of Newick in the County of Sussex

Celia Davies, Professor Emerita, The Open University

Baroness Emerton of Tunbridge Wells in the County of Kent and of Clerkenwell in the London Borough of Islington

Fiona Ross, Dean of Faculty of Health and Social Care Sciences, Kingston University and St George's, University of London

Secretariat

Yolanda Ferguson, office manager, Royal College of Nursing

Jenny Gordon, programme manager - Evidence for Practice, Royal College of Nursing

Ian Hulatt, mental health adviser, Royal College of Nursing

Nik Payne, nursing coordinator, Royal College of Nursing

Jane Salvage, independent nursing consultant and writer

Appendix 2: Commissioned background papers

Chandan M, Watts C (2012). *Mentoring and pre-registration nurse education*. Available at: <http://www.williscommission.org.uk>

Currie L, Watts C (2012). *Preceptorship and pre-registration nurse education*. Available at: <http://www.williscommission.org.uk>

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Watts C, Gordon J (2012a). *Pre-registration nurse education: overview of themes from the literature*. Available at: <http://www.williscommission.org.uk>

Watts C, Gordon J (2012b). *Leadership and pre-registration nurse education*. Available at: <http://www.williscommission.org.uk>

Appendix 3: Evidence received

Written evidence

Organizations

All Wales Children's and Young People's Representative Nurse Forum
Alzheimer's Society
Arthritis Research UK
Association of Chief Children's Nurses/Child Health Academic Community
Bangor University
British Heart Foundation
Birmingham City University
Buckinghamshire New University
Cambridge University Hospitals
NHS Foundation Trust
Carers UK
Centre for the Advancement of Interprofessional Education
Chartered Society of Physiotherapy
Chief Nursing Officer, Welsh Government
Chronic Pain Policy Coalition
Council of Deans of Health
Department of Health, Social Services and Public Security, Northern Ireland
Diabetes UK
Dignified Revolution
Edge Hill University
Edinburgh Napier University
Faculty of Occupational Medicine
Four Seasons Health Care
Glyndŵr University
Health and Social Care Board, Northern Ireland
Heart of England NHS Foundation Trust

Higher Education Funding Council for England
 Independent reference group (Audrey Emerton, Elizabeth Fradd, Tricia Hart, Anne Marie Rafferty, Stephen Moss, Flo Panel-Coates)
 Institute of Health Visiting
 Keele University
 Kingston University and St George's, University of London
 London South Bank University
 Macmillan Cancer Support
 Mental Health Nurse Academics
 Mind
 Multiple Sclerosis Society
 National Rheumatoid Arthritis Society
 NHS Commissioning Board Special Health Authority
 NHS Education for Scotland
 NHS Employers
 NHS London
 NHS Midlands & East
 NHS National Genetics Education and Development Centre
 NHS South of England
 Northern Ireland Practice and Education Council for Nursing and Midwifery
 Oxford Brookes University
 Patients Association
 Plymouth University
 Queen Margaret University, Edinburgh
 Queen's Nursing Institute
 Queen's Nursing Institute Scotland
 Queens University Belfast
 Royal College of General Practitioners
 Royal College of Midwives
 Royal College of Nursing Diversity Committee
 Royal College of Nursing Education Forum
 Royal College of Nursing Students Committee
 Royal College of Ophthalmologists
 Royal College of Physicians
 Royal College of Psychiatrists
 Scottish Heads of Academic Nursing and Allied Health Professions
 Scotland's Executive Nurse Directors
 Swansea University, Centre for Innovative Ageing
 Swansea University, College of Human and Health Science
 Teesside University

The Open University
 UK Faculty of Public Health
 University of Central Lancashire
 University of Cumbria
 University of Dundee
 University of Glasgow
 University of Huddersfield
 University of Hull
 University of Leeds
 University of Lincoln
 University of Liverpool
 University of Manchester
 University of Northampton
 University of Nottingham
 University of Salford
 University of Southampton
 University of Sunderland
 University of Surrey
 University of Wolverhampton
 University of Worcester
 Walsall Healthcare NHS Trust

Individuals

Ian Anderson, president, Royal College of Physicians and Surgeons of Glasgow
 Linda Bailey, RCN public health forum
 Susan Barrett, adult nurse
 D Bates, University of Southampton
 Amelia Bertram
 Dame Claire Bertschinger, London School of Hygiene & Tropical Medicine
 Sharon Black, director of practice learning
 Hilary Butterworth
 Ruth China, nurse
 Elizabeth Clarke, nursing student
 Richard Crofts, nursing student
 Paul Dalpra, nursing student
 Robin Dibblee, community mental health nurse/lecturer, University of Hertfordshire
 Lizzie Drake, nurse educator
 Audrey Emerton, House of Lords
 Mark Haith, nursing lecturer
 Antonia Hammond, nursing student
 Patricia Haward, retired nurse
 Heather Hawley, advanced nurse practitioner
 Liz Herd, clinical educator
 Michael Hetreed, retired nurse
 Moe Holmberg, adult nurse and mentor
 Louise Hunt, Lead Nurse for

Practice, Birmingham City University
 Julie Hyde, nurse, Institute of Healthcare Management
 S James
 Joanne Lord, nursing student
 Vanessa Martin, nurse
 Sue McBean, lecturer
 Chris McLean, lecturer, University of Southampton
 Karen Miles, nurse
 Kate Montague, nurse
 Sean Morton, senior lecturer
 Jane Murkin
 Valerie Outhwaite, RCN Bedfordshire branch
 Irena Papadopoulou, professor, Middlesex University
 Melanie Parsons, staff nurse
 Melanie Patterson, nursing student
 Mark Rawlinson, pathway leader - district nursing, University of Southampton
 Jean Rogers, nurse
 Jane Say, University of Hertfordshire
 Felicity Stockwell, researcher
 Alison Taylor, oncology nurse
 Roger Thompson, Praxis
 Alison Twycross, reader in children's nursing
 Cate Wood, lecturer, Bournemouth University
 James Youll, nurse

Oral evidence

Jenny Aston, chair, Nursing Group, GP Foundation, Royal College of General Practitioners
 Amy Bowen, director of service development, Multiple Sclerosis Trust
 Tony Butterworth, interim chair, NHS Institute for Innovation and Improvement
 Peter Carter, chief executive and general secretary, RCN
 Alison Cobb, senior policy and campaigns officer, Mind
 Rosemary Cook, director, Queen's Nursing Institute
 Jessica Corner, vice chair, Council of Deans
 Judith Ellis, interim chair, Nursing and Midwifery Council
 Iona Heath, president, Royal College of General Practitioners

Jill Macleod Clarke, University of Southampton
 Vicki Matthews, specialist nurse advisor, Multiple Sclerosis Trust
 Rita Newland, director of education, Nursing and Midwifery Council
 Peter Nightingale, president, Royal College of Anaesthetists
 Sir Keith Pearson, chair, Health Education England
 Carol Pook, head of school, Buckinghamshire New University
 Anne Marie Rafferty, professor, King's College London
 Fiona Ross, dean, faculty of health and social care sciences, Kingston University and St George's, University of London
 David Sines, pro vice chancellor, Buckinghamshire New University
 Stephanie Smith, policy officer, Council of Deans
 Donna Venetico, learning disabilities nurse, The Children's Trust
 Pauline Walsh, Education Forum, Royal College of Nursing
 Gavin Wollacott, East Midlands representative, RCN Students Committee
 Stuart Young, chair of RCN Students, and student member of RCN Council

Additional information received

General Dental Council
 General Medical Council
 General Optical Council
 General Osteopathic Council
 General Pharmaceutical Council
 Health and Care Professions Council
 Nursing and Midwifery Council
 Pharmaceutical Society of Northern Ireland
 Royal College of Nursing

Appendix 4: Meetings, events and site visits

Meetings held

Viv Bennett, Director of Nursing, Department of Health (England)
 Sally Brearley, chair, Nursing and Care Quality Forum
 Jane Cummings, Chief Nursing Officer, England
 Ann Farenden, National Nurse Adviser, Care Quality Commission
 David Foster, Deputy Director of Nursing, Department of Health (England)
 Elizabeth Jelfs, Director of Policy, Council of Deans of Health
 Angela McLernon, Acting Chief Nursing Officer, Northern Ireland
 Jean White, Chief Nursing Officer, Wales
 Postgraduate diploma in nursing students: Beth Codrington, Sophie Foxall, Richard Greenwood, Celia Hall, Caroline Medcraft, Kelly O'Connell, Claire Simpson and Jane Tottman

Events and site visits

Lord Willis undertook the following visits:

- RCN Congress, Harrogate, 16 May
- Dundee, 6 July
- Huddersfield, 16 July
- Cardiff, 26 July
- Belfast, 10 September
- Oxford, 12 September

Lord Willis engaged with the following people and organizations on his visits:

RCN Congress, Harrogate

Lord Willis hosted a meeting of around 50 self-selected Congress participants and RCN officials, including nursing students, educationalists and practitioners. He also attended a meeting of nursing students.

Dundee

Elizabeth Adamson, Practice Education Facilitator, NHS Fife
 Tony Barr, Field Lead, Adult Nursing, University of Dundee
 Anne Buchanan, Director of Nursing, NHS Fife
 Emma Burnett, Lecturer, Infection Control
 Joan Cameron, Lead Midwife in Education, University of Dundee
 Maureen Campbell, Lecturer, University of Dundee
 Lindsay Dingwall, Lecturer, University of Dundee
 Jennifer Donachie, School Secretary, University of Dundee
 Colette Ferguson, Director, NHS Education for Scotland
 Susanne Forrest, Programme Director, NHS Education for Scotland
 Theresa Fyffe, Director, RCN Scotland
 Janice McDougall, Practice Education Facilitator, NHS Fife
 Kevin McFarlane, Child Field Leader, University of Dundee
 Margaret McGuire, Director of Nursing, NHS Tayside
 Eileen McKenna, Associate Nurse Director, Access NHS Tayside
 Emma McNaughtan, nursing student, University of Dundee
 Irene McTaggart, Senior Lecturer in Nursing, University of Dundee
 Roma Maguire, Senior Research Fellow
 Heather Marr, Senior Lecturer, University of Dundee
 Isabel Paterson, Undergraduate Access & Admissions Tutor, University of Dundee
 Ann Payne, Programme Manager, Mental Health, University of Dundee
 Flora Pike, nursing student/class president, University of Dundee
 Janice Rattray, Reader/Senior Lecturer, University of Dundee
 Mike Sabin, Associate Director, NHS Education for Scotland
 Gill Smith, Practice Education Facilitator, NHS Tayside
 Moira Thomson, Project Assistant, NHS Education for Scotland
 Kay Wilkie, Senior Lecturer/QAAG Lead, University of Dundee

Huddersfield

Sue Bernhauser, Dean of Human & Health Sciences, University of Huddersfield
 Bob Cryan, Vice Chancellor, University of Huddersfield
 Niall Dew, Head of Practice Learning, University of Huddersfield
 Rona Ellis, Senior Lecturer, University of Huddersfield
 Karen Johnson, Children's Service Manager, LOCALA Community Partnerships
 Cath O'Halloran, Head of Department, Health Sciences, University of Huddersfield
 Christine Rhodes, Head of Pre-Registration Nursing, University of Huddersfield
 Julie Robinson, Chief Executive, St Anne's Community Services
 Gwen Ruddlesdin, Head of Integrated Quality & Governance, LOCALA Community Partnerships
 Sophie Rudiman, nursing student
 George Smith, Assistant Director of Nursing Education, Leadership and Development, South West Yorkshire Partnership NHS Foundation Trust
 Stephanie Smith, Council of Deans
 Helen Thomson, Director of Nursing, Calderdale & Huddersfield NHS Foundation Trust
 Miranda Usher, nurse mentor

Cardiff

Rhian Barnes, Professional Head of Adult Nursing, University of Glamorgan
 Simon Cassidy, Lead Practice Facilitator, Abertawe Bro Morgannwg University Health Board
 Jean Dadge, Practice Facilitator, Aneurin Bevan Health Board
 Moira Davies, Lecturer, University of Glamorgan
 Tina Donnelly, Director, RCN Wales
 Ellie Durstan, nursing student, University of Glamorgan
 David Gillimore, College of Human and Health Sciences, Swansea University
 Oliver Griebel, clinical mentor, Abertawe Bro Morgannwg University Health Board
 Sue Harris, Lecturer, University of Glamorgan

Adele Hood, Education & Development Manager, Aneurin Bevan Health Board
 Katie Johnson, Clinical Mentor, Abertawe Bro Morgannwg University Health Board
 Anna Jones, Lecturer, Cardiff University
 Elfrys Jones, Welsh speaker
 Lynne Jones, Head of Workforce, Education & Research, Abertawe Bro Morgannwg University Health Board
 Sara Jones, Director of Unscheduled Care/Clinical Director, Welsh Ambulance Service NHS Trust
 Janet Keggie, Clinical Teacher, Cardiff and Vale University Health Board
 Gillian Knight, Associate Lecturer, Velindre Cancer Centre
 Helen Knight, Senior Education & Development Manager, Aneurin Bevan Health Board
 Hannah Lane, nursing student, University of Glamorgan
 David Murray, Patient Panel Chair, Aneurin Bevan Health Board
 Stuart Nixon, patient representative and chair's Disability Advisory Group, Aneurin Bevan Health Board
 Julia Pearson, Education Liaison Nurse, Hywel Dda Health Board
 Mandy Rayani, Assistant Director of Nursing, Cardiff and Vale University Health Board
 Nicola Ryley, Assistant Director of Nursing, Aneurin Bevan Health Board
 Robert Sainsbury, Head of Integrated Services for Adult Social Care & Health, Aneurin Bevan Health Board
 Jane Thomas, Acting Head, College of Human and Health Sciences, Swansea University
 Dafydd Trystan, Registrar, Coleg Cymraeg Cenedlaethol
 Dianne Watkins, Reader, Cardiff University
 Paul Worthington, Chief Officer, Cwm Taf Community Health Council

Belfast

Kevin Anderson, nursing student, University of Ulster
 Owen Barr, Head of School, University of Ulster
 Marilyn Beare, Lecturer, University of Ulster
 Margaret Bennett, Practice

Education Facilitator, Southern Health & Social Care Trust
 Rhonda Brown, Practice Education Facilitator, Belfast Health & Social Care Trust
 Ann Butler, nurse mentor, Southern Health & Social Care Trust
 Frances Cannon, Senior Professional Officer, Northern Ireland Practice & Education Council for Nursing & Midwifery
 Elaine Connelly, Senior inspector, Independent Health Care, Dental Regulation
 Katrina Donnelly, nurse mentor, Western Health & Social Care Trust
 Angela Drury, Senior Professional Officer, Northern Ireland Practice & Education Council for Nursing & Midwifery
 Dawn Ferguson, Acting Practice Education Coordinator, Southern Health & Social Care Trust
 Kathy Fodey, Nursing Officer, Department of Health, Social Services and Public Safety
 Donna Gallagher, Senior Lecturer, Open University
 Gene Gillease, Crisis Service Manager for Mental Health, Western Health & Social Care Trust
 Maria Gillespie, nursing student, Open University
 Siobhan Gilmore, nursing student, Open University
 Kevin Gormley, Lead Discipline Post-registration, Queen's University Belfast
 Mandy Hawthorne, Ward Sister/ Charge Nurse, Belfast Health & Social Care Trust
 Mary Hawthorne, Associate Lecturer, Open University
 Mary Hinds, Director of Nursing & Allied Health Professionals, Public Health Agency
 Jennifer Kerr, nursing student, Queen's University Belfast
 Caroline Lee, Assistant Director of Nursing, Workforce and Learning, Belfast Health & Social Care Trust
 Elish MacDougall, Practice Education Coordinator, Belfast Health & Social Care Trust
 Olive MacLeod, Director of Nursing, Northern Health & Social Care Trust
 Gail McCabe, Team Leader, Southern

Health & Social Care Trust
Michelle McCartan, Ward Sister/
Charge Nurse, South Eastern Health
& Social Care Trust
Catherine McClelland, nursing
student, Queen's University Belfast
Carol McClinton, nursing student,
University of Ulster
Cathy McCoy, Ward Manager/Sister/
Charge Nurse, Northern Health &
Social Care Trust
Cathy McCusker, Senior Professional
Officer, Northern Ireland Practice
& Education Council for Nursing &
Midwifery
Mary McDervitt, Nurse Manager,
Western Health & Social Care Trust
Brendan McGrath, Assistant
Director of Nursing, Workforce,
Planning and Modernisation, Belfast
Health & Social Care Trust
Claire McGuigan, Practice Education
Coordinator, Northern Health &
Social Care Trust
Maeve McGuigan, Lead Public
Health Nurse, Northern Health &
Social Care Trust
Carole McKenna, Senior Professional
Officer, Northern Ireland Practice
& Education Council for Nursing &
Midwifery
Barry Magee, nursing student, Open
University
Moira Mannion, Co-Director, Belfast
Health & Social Care Trust
Garrett Martin, Deputy Director,
RCN Northern Ireland
Sally Martin, Practice Education
Coordinator, Western Health &
Social Care Trust
Ciara Milligan, nurse mentor, Belfast
Health & Social Care Trust
Evelyn Mooney, Practice Education
Coordinator, South Eastern Health &
Social Care Trust
Claire Murnin, nurse mentor, South
Eastern Health & Social Care Trust
Mary O'Hara, Ward Sister/Charge
Nurse, Southern Health & Social
Care Trust
Charrise Rainey, nurse mentor,
Causeway Hospital, Northern Health
& Social Care Trust
Kellie Rainey, nursing student,
Queen's University Belfast
Francis Rice, Director of Nursing,
Southern Health & Social Care Trust

Zara Stewart, nursing student,
University of Ulster
Marian Traynor, Lead Discipline
Practice, Queen's University Belfast
Diane Wilson, Primary Care
Manager, South Eastern Health &
Social Care Trust

Oxford

Lowrie Aldworth, nursing student,
Oxford Brookes University
Liz Barber, ward sister, Oxford
Health NHS
Ria Betteridge, clinical nurse
specialist, Oxford Health NHS
Juliet Bostwick, principal lecturer,
Oxford Brookes University
Bridgette Brogden, professional
education facilitator, Oxford Health
NHS
Chris Bulman, Faculty of Health
& Life Sciences, Oxford Brookes
University
Claire Chambers, Faculty of Health
& Life Sciences, Oxford Brookes
University
Leanne Cobham, nursing student,
Oxford Brookes University
Sarah Curtis, ward sister, Oxford
Cancer Centre
David Daly, nursing student, Oxford
Brookes University
Nettie Dearman, divisional nurse,
Oxford Health NHS
Nicky Edleston, learning
environment lead, Ridgeway
Partnership, Oxfordshire Learning
Disability NHS Trust
Ann Ewens, department head,
Oxford Brookes University
Lindsay Fisher, nursing student,
Oxford Brookes University
Carol Forde-Johnston, lecturer
practitioner, Oxford Health NHS
Mike Foster, deputy lead nurse,
Oxford Health NHS
Clare Foxon, nursing student, Oxford
Brookes University
Rosie Fry, nursing student, Oxford
Brookes University
June Girvin, Pro Vice Chancellor/
Dean, Oxford Brookes University
Merrilyn Hall, graduate nurse
(adult), Oxford Brookes University
Angela Houlston, matron, Oxford
Radcliffe Hospitals NHS Trust
Kim Hughes, nursing student,

Oxford Brookes University
Robyn Jones, nursing student,
Oxford Brookes University
Jennifer McKenna, paediatric
research nurse, University of Oxford
Carla McMahon, clinical educator,
Oxford Radcliffe Hospitals NHS
Trust
Claire Merriman, Faculty of Health
& Life Sciences, Oxford Brookes
University
Sir Jonathan Michael, Chief
Executive, Oxford University
Hospitals NHS Trust
Liz Monaghan, ward sister, Sobell
House NHS Hospice, Oxford
Sandy Oldfield, Faculty of Health
& Life Sciences, Oxford Brookes
University
Tracy Pearce, lecturer practitioner,
Oxford University Hospitals NHS
Trust
Amy Redhead, staff nurse, Oxford
Radcliffe Hospitals NHS Trust
Nicola Robertson, matron, Oxford
University Hospitals NHS Trust
Gerry Shepherd, Faculty of Health
& Life Sciences, Oxford Brookes
University
Elaine Strachan-Hall, Chief Nurse,
Oxford University Hospitals NHS
Trust
Gamu Tendayi, learning disabilities
nurse, Ridgeway Partnership,
Oxfordshire Learning Disability
NHS Trust
Katherine Walkey, professional
education facilitator, Oxford
University Hospitals NHS Trust
Helen Walthall, principal lecturer,
Oxford Brookes University
Nigel Welman, Faculty of Health
& Life Sciences, Oxford Brookes
University
Sharon Westcarr, paediatric research
nurse, University of Oxford
Liz Westcott, department head,
Oxford Brookes University
Louise Willis, paediatric research
nurse, University of Oxford
Rob Wondrak, Faculty of Health
& Life Sciences, Oxford Brookes
University
Peter Zaagman, principal lecturer,
Oxford Brookes University

Quality with Compassion: the future of nursing education

This report from the independent Willis Commission on Nursing Education explores how pre-registration nursing education in the UK can create and maintain a workforce of competent, compassionate nurses fit to deliver future health and social care services. It also looks at the support that newly qualified nurses need to deliver high quality care.

The report says graduate nurses have played and will continue to play a key role in driving up standards. Patient-centred care should be the golden thread that runs through all nursing education. The focus must be on helping service users, carers and families to manage their own conditions and maintain their health, and involving them wherever possible in education recruitment, programme design and delivery.

Nurses and their organizations must stand up to be counted, it says, to restore professional pride and provide leadership and solutions to the challenges of poor care and a decline in public confidence. Their influence on the next generation of nurses is crucial at this critical moment in the profession's history.

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